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MEDICAL FUTILITY AND RELIGIOUS FREE EXERCISE

Teneille Ruth Brown*

INTRODUCTION

A tragic scenario has become all too common in hospitals across the United States. Dying patients pray for medical miracles when their physicians think that continuing treatment would render no meaningful benefit. This situation is unfortunately referred to as “medical futility.” A fraught term, “medical futility” covers any request for treatment that is considered inappropriate because it “merely preserves permanent unconsciousness or cannot end dependence on intensive medical care”¹ In these cases, physicians, who are less likely than their patients to rely on God as a means of coping with major illness, are at an impasse.² Their patients request everything be done so that they can have more time for God to intervene, but in the physician’s professional experience, *everything* will probably do *nothing*. What is the physician to do?

The conundrum is a modern one: medical technologies such as breathing machines and dialysis units can support human bodies almost indefinitely when many of our organs fail. But is there any limit on this technological imperative? Every state and the U.S. Constitution recognize that a patient has the legal right to *refuse* unwanted treatment, even if it is life-sustaining.³ However, there is no corresponding constitutional

*Professor of Law at the University of Utah, S.J. Quinney College of Law and Adjunct Professor of Internal Medicine at the University of Utah. This article is based in part on an empirical project I conducted and published as part of the 2015 Petrie-Flom Conference on Law, Religion and Health Care at Harvard Law School. A related article explores health care providers’ views of medical futility and religion. See Teneille Brown, *Accommodating Miracles*, in LAW, RELIGION, AND HEALTH IN THE UNITED STATES (Holly Fernandez Lynch, I. Glenn Cohen, & Elizabeth Sepper, eds., Cambridge University Press 2017). This research was also made possible in part through generous support from the Albert and Elaine Borchard Fund for Faculty Excellence.

¹ Lawrence J. Schneiderman, Nancy S. Jecker, & Albert R. Jonsen, *Medical Futility: Its Meaning and Ethical Implications*, 112 ANNALS INTERNAL MED. 949, 949 (1990).

² Farr Curlin et al., *Religious Characteristics of U.S. Physicians*, 20 J. GEN. INTERNAL MED. 629, 631–632 (2005).

³ *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 279 (1990) (“But for purposes of this case, we assume the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”); see

right to *demand* specific treatments.⁴ This is not simply about the ability to pay. Even if an individual's private insurance would cover aggressive treatments, or if the individual had the financial means to pay out of pocket, a physician need not offer treatments to a patient if in her judgment they would be medically ineffective, or futile. Tort law recognizes this professional deference by defeating a negligence claim if the physician complied with the medical standard of care.⁵

To underscore this professional deference, most states have passed so-called "medical futility statutes."⁶ These statutes make it explicit that physicians have immunity from negligence claims if a physician refuses to offer futile treatment, so long as particular statutory safeguards are met.⁷ Physicians are generally quite reluctant to invoke these statutes, but they are *particularly* reluctant to do so when the patient's request for treatment is based on a religious belief in miracles. There is a sense that religious reasons are different and should be given special consideration. Religious-based challenges to medical futility policies place individuals at odds with secular providers and the state, and "frequently generate particularly difficult questions about the proper relationship between religiously faithful citizens and the sovereign government."⁸ Even if there is no general legal entitlement to medical care and physicians may be immunized from negligence claims, can the invocation of a state's medical futility statute violate free exercise? This is the question I address in this article.

also *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1137 (1986) ("[A] person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment.") (citation omitted).

⁴ Abigail All. for Better Access to Dev. Drugs v. Von Eschenbach, 495 F.3d 695, 712 (D.C. Cir. 2007). For a discussion of the restrictions on the limited right to medical care for prison inmates under the Eighth and Fourteenth Amendments, see also Carl Drechsler, Annotation, *Relief Under Federal Civil Rights Acts to State Prisoners Complaining of Denial of Medical Care*, 28 A.L.R. Fed. 279 (1976).

⁵ Joseph H. King, *The Common Knowledge Exception to the Expert Testimony Requirement for Establishing the Standard of Care in Medical Malpractice*, 59 ALA. L. REV. 51, 51 (2007).

⁶ Thaddeus Mason Pope, *Medical Futility Statutes: No Safe Harbor to Unilaterally Refuse Life-Sustaining Treatment*, 75 TENN. L. REV. 1, 1 (2007) ("Over the past fifteen years, a majority of states have enacted medical futility statutes that permit a health care provider to refuse a patient's request for life-sustaining medical treatment.").

⁷ *Id.*

⁸ Michael Heise & Gregory C. Sisk, *Free Exercise of Religion Before the Bench: Empirical Evidence from the Federal Courts*, 88 NOTRE DAME L. REV. 1371, 1372 (2013).

This article has just two parts. The first part will contextualize the problem by describing the history of medical miracles, and why there are so many appeals to them in modern medical practice. The second part will explain why medical futility statutes do not violate a patient's religious free exercise, as this concept has developed under the Supreme Court's First Amendment jurisprudence and state and federal Religious Freedom Restoration Acts.

I. THE HISTORY AND UBIQUITY OF MEDICAL MIRACLES

A. All Five Major World Religions Promote Belief in "Miracles"

A 2013 Harris Poll indicated that a whopping 72% of Americans believe in divine miracles. This is down from previous polls, but still quite high compared to other Western countries.⁹ An older poll conducted by *Time*/CNN reported that 77% of Americans believed "that God sometimes intervenes to cure people who have serious illnesses."¹⁰ "This same poll report[ed] that 82% of Americans" believe in the power of prayer to heal the sick.¹¹ Eighty-two percent. We are hard-pressed to find any other question related to personal beliefs with such a high percentage of agreement.

Miracle narratives are found in all five of the major world religions, and healing miracles are prominent among them. However, the symbolic value and meaning of miracles is different in the context of each faith. For example, what we would today refer to as a "miracle" has no synonym in Hebrew. The writers of the Jewish bible had no conception of an occurrence that would violate the laws of nature, given that the divine and ordinary worlds could not be separated.¹²

⁹ Larry Shannon-Missal, *Americans' Belief in God, Miracles and Heaven Declines*, HARRIS POLL (Dec. 16, 2013), http://www.theharrispoll.com/health-and-life/Americans_Belief_in_God_Miracles_and_Heaven_Declines.html.

¹⁰ Claudia Wallis, *Faith and Healing*, *TIME*, June 24, 1996, at 58. Peter H. Van Ness & David B. Larson, *Religion, Senescence, and Mental Health*, *AM. J. OF GERIATRIC PSYCHIATRY* 386 (2002).

¹¹ *Id.*

¹² What we would today call "miracles" are clustered around the Moses stories of Exodus and Numbers, and the Elijah and Elisha stories in R. Walter L. Moberly, *Miracles in the Hebrew Bible*, in *THE CAMBRIDGE COMPANION TO MIRACLES* 62 (Graham Twelftree ed., 2011).

Hinduism,¹³ Buddhism,¹⁴ and Catholicism¹⁵ believe that modern miracle-workers exist among us and reinforce our faith. Each of these faiths discourages the display of miracles for their own sake, and enlightened Buddhists who publicize the miracles they perform are frowned upon.¹⁶ The centrality and significance of miracles varies depending on the religion. For example, the many documented miracles of Mohammed are “not at all as central to Muslim faith as the miracles of Jesus are to Christians.”¹⁷

In some religions such as Judaism and Islam, familiar stories that today would be described as “miracles” are contextualized as having occurred thousands of years ago—when new religions competed with magical paganism and needed to prove their divine power and truths.¹⁸ For millennia, Protestants also believed that miracles only occurred in biblical times.¹⁹ However, the notion of the “limited age of miracles” was reconsidered and largely abandoned by Protestant theologians in

¹³ Yogis perform “bodily feats which an outsider might judge to be superhuman”; “[t]hey can live for weeks without nourishment, endure fantastic extremes of heat and cold, go into suspended animation, stop breathing (or nearly so) for hours, [and] change their rate of heartbeat.” Even so, yogis would not likely describe this as a “miracle,” and instead they view these as “psychosomatic techniques that are done at will.” GEOFFREY ASHE, *MIRACLES* 131 (1st ed. 1978). The Hindu faith does not emphasize the distinction between the natural and the unnatural worlds, and so the word “miracle” possesses different connotations than it does for us today. The miracles of the Hindu faith are often the result of power-plays between a manifestation of a Hindu god, and some demon, where the Hindu god prevails and reveals his prowess. All of life is in God’s hands, and so while it seems that the gods are playful and sometimes spiteful, miracles are happening all of the time. KENNETH L. WOODWARD, *THE BOOK OF MIRACLES* 265–66 (2000).

¹⁴ The miracles of the Buddha, Siddhartha, take on cosmic proportions, and reveal his superiority over all other beings. The Buddha was the only being who had complete control of his final rebirth. He chose where, when, and in which family to be reborn for the last time. He also makes someone near him invisible to another and overpowers fiery dragons by himself bursting into flames. See Rupert Gethin, *Tales of Miraculous Teachings: Miracles in Early Indian Buddhism*, in *THE CAMBRIDGE COMPANION TO MIRACLES* 216, 221 (Graham H. Twelftree ed., 2011).

¹⁵ Peter Berger, *The Hospital: On the Interface Between Secularity and Religion*, 52 *SOCIETY* 410, 412 (2015).

¹⁶ WOODWARD, *supra* note 13, at 24.

¹⁷ While the moon was split in two at Mecca when Muhammed asked for a sign from Allah, and he repeatedly fed huge groups of people on tiny amounts of food, these miracles are not central to Muhammed’s biography. They are instead merely referenced in a list format. *Id.* at 184–85 (citing L. ZOLONDEK, *BOOK XX OF AL-GHAZALI’S IHYA’ ULUM AL-DIN* 45 (1963)).

¹⁸ ROBERT BRUCE MULLIN, *MIRACLES AND THE MODERN RELIGIOUS IMAGINATION*, 191–92 (Yale Univ. Press ed., 1996).

¹⁹ *Id.*

the early twentieth century in light of a need to explain the relationship between God and the modern world.²⁰

Whether God intervenes directly to perform modern miracles remains an essential question to many religious thinkers. What one group may refer to as mere providence or good luck, another might attribute to the indirect workings of God. This difficulty differentiating between good luck and divine intervention is nowhere more pronounced than in medicine. The relationship between the healing arts and religious miracles goes back to ancient times and carries through, in some denominations, to the present. The Greek God Asklepios performed miraculous medical feats, including curing facial injuries, kidney stones, weapon wounds, and blindness, and removing tumors, lice, worms, headaches, infertility, chest infections, and disfigured limbs.²¹ Incidentally, he sometimes used snakes in his treatments, and the rod of Asklepios, the snake-entwined staff, remains a leading symbol of medicine.²²

In the present day, Christians are the religious group that most frequently pray for, and expect, modern healing miracles.²³ This is perhaps unsurprising, as so many of Jesus Christ's miracles involved healing the sick and physically disabled.²⁴ Jesus makes the blind see; he renders the paralyzed able to walk; he cures lepers and epileptics.²⁵ Christ is even capable of healing from a distance, as when he removed the fever from a dying boy and restored him to health.²⁶ As Christian sects have divided and

²⁰ Since the early 1900s, Protestant clerics now state that the healing of the present day may be connected with the gifts of healing that the apostles exhibited in the bible. *Id.*

²¹ HOWARD CLARK KEE, *MIRACLES IN THE EARLY CHRISTIAN WORLD* 78–86 (Yale Univ. Press ed., 1983) (“[Asklepios the Healer] appears throughout these centuries not only as the agent of divine cures but also as the founder of the medical profession . . . as a human being with therapeutic skills, as a hero, and as a god . . . attempts to trace the development of this figure have not produced definitive results.”).

²² See *What's in a Symbol*, UF HEALTH, <http://humanism.med.ufl.edu/chapman-projects/art-of-medicine-project-2005-2006/whats-in-a-symbol/> (last visited Nov. 8, 2016).

²³ WOODWARD, *supra* note 13, at 21 (“[O]f all the world religions, Christianity is the one that has most stressed miracles.”).

²⁴ See Patrick J. Kiger, *What Do the World's Religions Say About Miracles?*, NAT'L GEOGRAPHIC, <http://channel.nationalgeographic.com/the-story-of-god-with-morgan-freeman/articles/what-do-the-worlds-religions-say-about-miracles/> (last visited Nov. 8, 2016).

²⁵ See *id.*

²⁶ WOODWARD, *supra* note 13, at 131.

subdivided, there exists great variety between groups in interpreting Jesus's biblical healing miracles. Some groups read these miracles metaphorically, while others view them as having occurred exactly as described.²⁷ Either way, the stories of Jesus's healing miracles hold a central place in the Christian ethos.

The role of healing miracles in Catholicism is particularly well documented. A fascinating and thorough review of the Vatican canonization archives demonstrates that 95% of more than 600 miracles performed by candidates for Catholic sainthood between 1600 AD and 2000 AD involved healing the sick or disabled.²⁸ The connection between miraculously healing the blind, epileptic, those suffering from tuberculosis, unknown paralysis, and other ailments has close scriptural connections to the Catholic faiths, and in the more modern experiences of evangelical Christian faiths.²⁹ Even so, this practice became marginalized with the rise of scientific medicine in the early twentieth century.³⁰

Healing miracles reappeared after 1945 in the Christian Pentecostalism movement.³¹ The practice of "praying for the sick was revived on a scale hitherto unknown."³² As a result, it became commonplace for many Christians to believe that God is "capable of effecting miraculous healings, with significant numbers claiming to have been 'healed' of physical or mental ailments."³³ This branch of Christianity spread throughout the world, particularly in West Africa, India, South Africa, and the Southern United States and gave rise to testaments where "paralytics arise from wheelchairs, stiff knees become flexible, cancerous ulcers disappear, and headaches vanish."³⁴ It is likely this cultural script or story has stuck with

²⁷ See Barry L. Blackburn, *The Miracles of Jesus*, in *THE CAMBRIDGE COMPANION TO MIRACLES* 113, 124 (Graham H. Twelftree ed., 2011).

²⁸ Jacalyn Duffin, *The Doctor Was Surprised; or, How to Diagnose a Miracle*, 81 *BULL. HIST. MED.* 699, 706 (2007); see also WOODWARD, *supra* note 13, at 367.

²⁹ Andrew Singleton, "Your Faith Has Made You Well": *The Role of Storytelling in the Experience of Miraculous Healing*, 43 *REV. RELIGIOUS RES.* 121, 121 (2001).

³⁰ *Id.*

³¹ *Id.*

³² *Id.* (quoting JOHN T. NICHOL, *PENTECOSTALISM* 221 (1966)).

³³ *Id.*

³⁴ Jorg Stolz, "All Things Are Possible": *Towards a Sociological Explanation of Pentecostal Miracles and Healing*, 72 *SOC. RELIGION* 456, 456, 458 (2011) ("When critics say that

many Americans and has provided modern exemplars of miraculous healing through prayer.

While not meant to be exhaustive, this brief and sweeping introduction may provide some context for the modern requests for miracles in hospitals across the country. Dating back to ancient times, references to miracles often involved the healing arts as well as the ability of God to change the shape of objects, triumph over supernatural demons, resurrect the dead, or light things on fire.³⁵ The rise of Christian miracle revival stories occurred simultaneously with the growth of modern medical technologies such as sterile surgery, chemotherapy, dialysis, or artificial breathing. In this post-scientific world, the idea that God could save you from floods or burning houses has somewhat receded from our popular landscape.³⁶ But medicine and healing remain a central part of our culture.³⁷ The role of miracle-making in this domain has ballooned where the stories of God proving his existence through threatening species extinction, contests between gods, or transmutation have diminished. The search for God in the modern world has settled on finding his presence in the hospital or clinic.

B. Religious Patients, Secular Physicians

The fact that people turn to religion in times of health crisis does not necessarily render the appeals to miracles suspect. If there were just one time in a person's life when she will pray for a miracle, it is likely to be at the bedside of a dying loved one. Medical crises often lead to intensification of religiosity and powerful religious conversions.³⁸ This phenomenon does not just

[Pentecostal] healers produce 'only a placebo effect,' these anthropologists answer that, precisely, the placebo effect shows that humans are a socio-psycho-physical entity in which the symbolic may have an effect on the physical[.]") (citations omitted).

³⁵ WOODWARD, *supra* note 13, at 63–64, 69–70, 130–31.

³⁶ See e.g. Michael Lipka, *Why American's 'Nones' Left Religion Behind*, PEW RESEARCH CENTER, Aug. 24, 2016, <http://www.pewresearch.org/fact-tank/2016/08/24/why-americas-nones-left-religion-behind/#>.

³⁷ For a representative collection of movies, novels, and other popular culture items that feature medicine, spirituality, and healing, see Jenn Lindsay, Larry A. Whitney & Stephanie N. Riley, *Spirituality, Medicine, & Health – Popular Culture*, BOSTON UNIVERSITY PERSONAL WEBSITES

http://people.bu.edu/wwildman/smh/content_popculture.htm.

³⁸ Kenneth Ferraro and Jessica Kelley-Moore, *Religious Consolation Among Men and Women: Do Health Problems Spur Seeking?* 39 J. OF SCI. STUDY OF RELIGION 220, 226–

hold for religious nations, where the religious beliefs parallel the level of religious practice. The more secular a nation is in its public sphere and religious practice, the *more likely* its citizens are to turn to hospitals as religious forums when disease strikes.³⁹ As one researcher put it, in the low-religiosity nation of Denmark, the “[p]rayer houses . . . are no longer the churches but the hospitals.”⁴⁰

There is an intense sociological connection between our culture and the way we die. In addition to the rich history of religiously moderated medical miracles, patients may separately hope for a miracle because of significant changes in the way Americans experience death. In the early part of the last century, we used to die at younger ages, from infections, childbirth, and wounds.⁴¹ We now have nearly doubled our life expectancy from 47 years in 1900 to 78 in 2008.⁴² We are less likely to die from acute infections, and are more likely to die of chronic conditions like heart failure, cancer, and diabetes.⁴³ Many now believe that “sickness, pain, and premature death were no longer viewed as immovable points on the human landscape, but as problems that could be removed through human intelligence and ingenuity.”⁴⁴

This raises another important change in the sociology of the Western Christian world: the “mundanization” of ordinary life.⁴⁵ While earlier Christian cultures in the United States and elsewhere focused on the after-life, there is much greater focus now on *this* life.⁴⁶ Put differently, while good Christians used to

227 (2000).

³⁹ Niels Christian Hvidt, *Patient Belief in Miraculous Healing: Positive or Negative Coping Resource?*, in *THE CAMBRIDGE COMPANION TO MIRACLES* 309, 311 (Graham H. Twelftree ed., 2011) (footnote omitted).

⁴⁰ *Id.*

⁴¹ Tenielle R. Brown, *Denying Death*, 57 ARIZ. L. REV. 977, 980 (2015) [hereinafter Brown I].

⁴² *Id.* at 981.

⁴³ *Id.* There is some data to suggest that our life expectancies continued to rise in the latter part of the 20th century, and was correlated with passage of the Medicare Act. However, other countries saw an increase in their life expectancies around the same time and so it is not clear whether the correlation is in fact causal. See Muriel Gillick, *How Medicare Shapes the Way We Die*, 8 J. HEALTH & BIOMED. L. 27, 33 (2012); *Expectation of Life at Birth, 1970 to 2008, and Projections, 2010 to 2020, Table 104*, STAT. ABSTRACT U.S. 77 (2012), <http://www.census.gov/compendia/statab/2012/tables/12s0104.pdf>.

⁴⁴ MULLIN, *supra* note 18, at 85.

⁴⁵ *Id.* at 86.

⁴⁶ *Id.*

work toward a good death, now they work toward a good life. Death became a scientific phenomenon to be solved by mortals.⁴⁷ This presented a dramatic change in how Americans died. We used to die at home, surrounded by loved ones.⁴⁸ We struggled to practice a good or “holy” death, where we gracefully accepted the will of God, welcomed the chance to atone our sins, and did not treat illness as a war to be won.⁴⁹ Conversely, the opposite is now true. The degree of one’s religious coping is now positively correlated with receiving more intensive and life-prolonging care.⁵⁰

Despite the fact that most Americans would still prefer to die at home, most of us no longer do; we are much more likely to die in hospitals, acute care facilities, or intensive care units.⁵¹ Hospitals used to be staffed by Catholic nuns when they first began as religious charities that served the poor.⁵² However, hospitals are now are much more likely to serve all socioeconomic groups and have a secular and for-profit corporate structure.⁵³ The secular orientation of most of these facilities means that health care providers (“providers,” going forward) generally do not see their role as a spiritual one.⁵⁴ Even if they are religious in their private lives, they do not see this as bearing on their clinical work.⁵⁵ This means that while

⁴⁷ DREW GILPIN FAUST, *THIS REPUBLIC OF SUFFERING: DEATH AND THE AMERICAN CIVIL WAR* 6–7 (2008).

⁴⁸ *Id.*

⁴⁹ *Id.* at 6–10 (“The concept of the Good Death was central to mid-nineteenth-century America, as it had long been at the core of Christian practice. Dying was an art, and the tradition of *ars moriendi* had provided rules of conduct for the moribund and their attendants since at least the fifteenth century: how to give up one’s soul ‘gladly and wilfully’; how to meet the devil’s temptations of unbelief, despair, impatience, and worldly attachment...”).

⁵⁰ Hanneke W. M. van Laarhoven, Johannes Schilderman & Judith Prins, *Religious Coping and Life-Prolonging Care*, 302 J. AM. MED. ASS’N. 257, 257 (2009).

⁵¹ *Id.*

⁵² Barbra Mann Wall, *The Pin-Striped Habit: Balancing Charity and Business in Catholic Hospitals, 1865–1915*, 51 NURSING RES. 50, 50 (2002) (“Between 1865 and 1915, Catholic sister-nurses built impressive hospital networks throughout the United States. These hospitals were, first, manifestations of religious and charitable ideals.”).

⁵³ Martha Minow, *Partners, Not Rivals?: Redrawing the Lines Between Public and Private, Non-Profit and Profit, and Secular and Religious*, 80 B.U. L. REV. 1061 (2000); Jason M. Kellhofer, *The Misperception and Misapplication of the First Amendment in the American Pluralistic System: Mergers Between Catholic and Non-Catholic Healthcare Systems*, 16 J.L. & HEALTH 103 (2002).

⁵⁴ Curlin et al., *supra* note 3, at 632.

⁵⁵ *Id.*

hospitals are the location of death for most of us, they are usually ill-equipped to deal with the religious aspects of death.

While very recent trends show that fewer Americans are dying in hospitals or nursing homes, about 70% still do,⁵⁶ and many die just days after receiving aggressive care.⁵⁷ This relatively new shift from dying at home to dying in a facility may have disrupted cultural notions about the role of health care providers in the end of life. Of course, nurses and doctors treat infection, prematurity, pain, heart disease and cancer, but when these treatments are offered so near one's death, how could the clinical work be so neatly divided from the spiritual?

Medicine has really struggled with this new normal. Indeed, providers and staff are less religious than the patients they treat on average, and are distressed when patients are perceived to shut down the end-of-life conversation by playing the "trump card" of "waiting for a miracle."⁵⁸ Many studies report that providers feel untrained and uncomfortable discussing the spiritual aspects of end of life care.⁵⁹ It is no wonder that the majority of Americans report that providers never spoke to them about what they want their death to be like,

⁵⁶ See CDC, DEATH STATISTICS (Apr. 9, 2008),

http://www.cdc.gov/nchs/data/dvs/Mortfinal2005_worktable_309.pdf.

⁵⁷ Murray Enkin et al., *Death Can Be Our Friend: Embracing the Inevitable Would Reduce Both Unnecessary Suffering And Costs*, 343 BRIT. MED. J. 1277, 1277 (2011) ("Too many people are dying undignified graceless deaths in hospital wards or intensive care units, with doctors battling against death way past the point that is humane."); see Derek C. Angus et al., *Use of Intensive Care at the End of Life in the United States: An Epidemiologic Study*, 32 CRITICAL CARE MED. 638–643 (2004) (nearly forty percent of all deaths nationwide occur in the acute care setting and approximately twenty percent involve the use of intensive care services); Alvin C. Kwok et al., *The Intensity and Variation of Surgical Care at the End of Life: A Retrospective Cohort Study*, 378 THE LANCET 1408, 1408 (2011) ("A fifth of elderly Americans die in intensive-care services and of these patients, about half undergo mechanical ventilation and a quarter undergo cardiopulmonary resuscitation in the days before death. Furthermore, the intensity of end-of-life care varies substantially on the basis of the facility where patients receive care.").

⁵⁸ Paul R. Helft, *Waiting for a Miracle*, CANCER NETWORK: ONCOLOGY J. (2014), <http://www.cancernetwork.com/oncology-journal/waiting-miracle#sthash.YPtTbtXB.dpuf> ("[A]lthough it is clear from national survey data that US adults are extraordinarily likely to believe that such supernatural events as divine healing can occur, healthcare professionals are consistently less likely to believe in them. However, because of the special respect we give to faith-based claims, 'waiting for a miracle' can become a sort of 'trump card' that is capable of shutting down further attempts to limit treatments.").

⁵⁹ Bernard Lo et al., *Discussing Religious and Spiritual Issues at the End of Life: A Practical Guide for Physicians*, 287 J. AM. MED. ASS'N. 749, 749 (2002).

or the spiritual aspects of these medical decisions.⁶⁰ Given this portrait, how could this imperfect mixing of the roles of the religious and the medical *not be* perplexing to most Americans? How could it not lead to moral confusion about the role of prayer and religious belief at the end of life? Physicians shepherd their patients through the war on death, but often do little to prepare them for when the battle is ultimately lost.

Another important factor in this equation is the development of artificial life support. More Americans are dying in medical facilities precisely because they are suffering from organ failure that can be supported by relatively new medical devices.⁶¹ A disorder that would have led to an imminent death a hundred years ago can now be treated with machines, and reimbursed through insurance. Our kidneys can be dialyzed, our stomachs can be fed through tubes, our lungs can be ventilated, our bladders can be evacuated, our hearts can be pumped, and our diaphragms can be paced. The advent of these life-sustaining devices is miraculous in one sense of the word, as life can be artificially supported, sometimes indefinitely. However, these advances also challenge our religious beliefs about when to give up hope and acknowledge it is the end. Artificial life support certainly challenges our very definitions of death. Is someone with minimal brain activity, but who is breathing, eating, and performing other life functions that are only possible because of artificial support from machines, still alive? In this metaphysical sense, medicine has been a victim of its own success.

The cultural, religious, institutional and technological developments of the last century have led us to rely on doctors as our partners in fighting death. With more and more medicines, procedures, and data, physicians have become modern day miracle workers in combatting death and disease. They have been our partners in this fight. In one study, eighty percent of Southern respondents viewed physicians as “God’s mechanics.”⁶² But these same doctors are not theologians, they

⁶⁰ Brown I, *supra* note 42, at 987–988.

⁶² Suzanne Prevost & J. Brandon Wallace, *Dying in Institutions*, in *DECISION MAKING NEAR THE END OF LIFE: ISSUES, DEVELOPMENT, AND FUTURE DIRECTIONS* 189–90 (James Werth and Dean Blevins eds., 2008).

⁶² Forty percent believed “God’s will is the most important factor in recovery,” and

are healers, and increasingly driven by data. When we ask these same people to take seriously the hope for religious prayer, some are sympathetic, but many see this final pursuit as outside the realm of their expertise.⁶³

The progress of modern medicine has led us to mutually engage in recovery narratives with our doctors. We are fighting cancer, heart disease, together. We will try subsequent treatments, and we will prevail. But of course this is the optimistic narrative physicians tell, to keep patients hopeful and to avoid uncomfortable conversations about near death. Patients and their surrogates may be particularly flummoxed when providers refer to any additional treatment as “futile,” and recommend withdrawing life-sustaining treatment. Why are these doctors, who have been helping us fight death for so long, suddenly giving up? Do they not believe in miracles? Did they lose their faith? Why will they not give this loved one just a little more time?

It is not always religious differences that motivate conflicts over medical futility. In some cases, the provider’s financial motives, as a steward of hospital or insurance resources, might be questioned.⁶⁴ The surrogate might also distrust the provider on a more personal level, and wonder whether their loved one is being hustled toward death because of his lack of education and money, or because of his race or ethnicity.⁶⁵ Even when the conflict is not borne of distrust, the surrogates might still be in denial of their loved one’s prognosis, and unable to come to grips with the fact that she will never return to the way she was. The provider, as the bearer of this

the study found that spiritual faith in healing was stronger among women than men. Christopher J. Mansfield et al., *The Doctor as God’s Mechanic? Beliefs in the Southeastern United States*, 54 SOC. SCI. & MED. 399–409 (2002).

⁶³ This sentiment is based on my experience on hospital ethics committees and the response to requests for religious miracles.

⁶⁴ Rationing and futility are two different things. “Rationing refers to the allocation of beneficial treatments among patients; [whereas] futility refers to whether a treatment will benefit an individual patient.” Robert D. Truog, *Medical Futility*, 25 GA. ST. U.L. REV. 985, 990 (2009) (quoting Lawrence J. Schneiderman et al., *Medical Futility: Its Meaning and Ethical Implications*, 112 ANNALS INTERNAL MED. 985, 988 (1996)).

⁶⁵ “Futility cases most commonly involve patients and families from the more marginalized and disadvantaged segments of our society. These are families who have lived on the outskirts of our healthcare system, and who have frequently been denied or perceive that they have been denied, care that is beneficial.” *Id.* at 988.

dark and unhelpful news, may be punished for being the messenger. While each of these is important and can work in tandem with other reasons, I am not addressing any of them specifically in this article. Here I will focus on the situation where the patient, surrogate or family believe in God's divine ability to work miracles, and are concerned that this belief is not mirrored or supported by the hospital or staff.

For the surrogate who wants to conserve life, there are likely asymmetrical costs. If we pray for a miracle, it just might happen, but if we withdraw or discontinue life-sustaining treatments, our loved one will almost certainly die. Many things may fuel this belief in miracles: religious tradition, personal spirituality, or even a pop culture recollection of a patient who suddenly "woke up" after years of being on a ventilator.⁶⁶ They hope that their loved one will similarly beat the odds, and they are disappointed that the clinicians hold out no such hope. They are not thinking of balancing data on probable outcomes, costs, and availability of hospital beds. They are understandably just thinking of their loved one.

When patients or families contest the withdrawal of treatment, it puts providers in a very uncomfortable position. In addition to being empiricists rather than theologians, providers may have chosen their profession because they saw something special in the doctor-patient relationship. The latter part of the twentieth century saw a transition in this relationship from a model of "doctor knows best" toward a model that prioritizes the autonomy and wishes of the patient.⁶⁷ This valuable shift has inadvertently engendered a more commercial model of health care, where the patient views herself as a customer.⁶⁸ It is fair to

⁶⁶ See, e.g., NICHOLAS SPARKS, *THE CHOICE* (Grand Central Publishing 2007) (where a woman wakes up after being in a coma for a significant period of time); *WHILE YOU WERE SLEEPING* (Buena Vista Pictures Distribution, Inc. 1995).

⁶⁷ Robert Veatch, *Doctor Does Not Know Best: Why in the New Century Physicians Must Stop Trying to Benefit Patients*, 25 J. OF MED. AND PHILOSOPHY 701, 702 (2000).

⁶⁸ Mark A. Hall, *The Legal and Historical Foundations of Patients As Medical Consumers*, 96 GEO. L.J. 583, 586 (2008); Robert Pearl, *Are You A Patient Or A Healthcare Consumer?*, FORBES (Oct. 15, 2015), <http://www.forbes.com/sites/robertpearl/2015/10/15/are-you-a-patient-or-a-health-care-consumer-why-it-matters/#68088ba65c3a> ("Advocates who insist on calling us 'consumers' believe that high-tech can solve nearly all of healthcare's challenges. They argue that in the digital age, control has shifted to the individual and must continue to do so.").

say that most providers do not like this trend.⁶⁹ They resist medicine becoming just another commercial good, “like breakfast cereal and toothpaste.”⁷⁰ And they do not want to be “indentured servants” or “grocers,” required to provide whatever treatment their patients and surrogates want.⁷¹ This offers yet another reason why the conflict between provider and family can become so intractable when the family demands certain life-sustaining care that the provider believes are inappropriate.

In addition to resisting the commercial model of health care, nurses and physicians also resist feeling complicit in “torturing” a patient with ventilators, pokes, and tracheotomies. If they chose their profession in order to heal, as most nurses and physicians do, then this can be emotionally draining if their present work feels diametrically opposed to this goal. This emotional toll may be especially pronounced when the patient is unlikely to receive any clinical benefit, but the treatments cause visible pain or distress.⁷² In these cases, appeals to medical futility may address the provider’s spiritual as well as professional needs. While the family is praying for a miracle, the provider might be hoping or praying for the patient’s physical pain to end, along with their role in perpetuating it.

C. Tragic (Sometimes Legal) Conflicts Between Patients and Providers

Some reading this will remember the case of Baby Rena, from the early 1990s. Baby Rena was HIV+ and had respiratory distress and cardiac failure.⁷³ She had excessive cerebral spinal fluid in her brain, kidney dysfunction, needed a ventilator to

⁶⁹ Pope, *supra* note 6, at 15.

⁷⁰ George Annas, *Asking the Courts to Set the Standard of Emergency Care – The Case of Baby K*, 330 NEW ENG. J. MED. 1542, 1545 (1994); see also Eric Gampel, *Does Professional Autonomy Protect Medical Futility Judgments?*, 20 BIOETHICS 92, 97 (2006); Pope, *supra* note 6, at 15.

⁷¹ See Pope, *supra* note 6, at 14–15.

⁷² See, e.g., Murray M. Pollack, *Surrogate Decision Makers and Respect: Commentary on “The Many Faces of Autonomy,”* 3 J. CLINICAL ETHICS 303, 303–304 (1992); Benjamin Weiser, *A Question of Letting Go: Child’s Trauma Drives Doctors to Reexamine Ethical Role Series: The Case of Baby Rena Series Number: 1/2*, WASH. POST, July 14, 1991, at A1 [hereinafter Weiser Part I]; Benjamin Weiser, *While Child Suffered, Beliefs Clashed Series: The Case of Baby Rena: Who Decides When Care Is Futile? Series Number: 2/2*, WASH. POST, July 15, 1991, at A1 [hereinafter Weiser Part II].

⁷³ Weiser Part I, *supra* note 72, at A1.

breathe, and had to be constantly sedated due to her expressions of pain.⁷⁴ A Christian couple who intended to foster Baby Rena remained hopeful in the face of her failing health, and were adamant that her care “be motivated by a spiritual sense of obedience to God.”⁷⁵ The treating doctor contended that the prognosis was grim and the ventilator be removed.⁷⁶ Despite initial successes breathing on her own, Baby Rena ultimately died on a ventilator after receiving cardio-pulmonary resuscitation.⁷⁷ The intended foster mother was “stunned,” as her faith held that health was there for anyone who would just claim it through prayer.⁷⁸

Since the popularized case of Baby Rena, the appeals for miraculous medical interventions have not subsided. The family of Bobbi Kristina Brown, daughter of Bobbi Brown and Whitney Houston, “asked friends and fans to pray for a miracle” in early 2015 after she nearly drowned in a bathtub and was rendered unconscious.⁷⁹ In the popular press, the 2013 case of Jahi McMath presents another tragic standoff between surrogates and hospital staff.⁸⁰ Jahi was an Oakland teenager who went into cardiac arrest after a routine tonsillectomy to alleviate sleep apnea.⁸¹ After being placed on a ventilator, the hospital staff declared the patient brain dead and suggested that the artificial support be withdrawn.⁸² Jahi’s mother insisted that as long as Jahi was on a ventilator and her heart was beating, God could work a miracle.⁸³ Unlike the Baby Rena case, this conflict

⁷⁴ *Id.*

⁷⁵ David M. Smolin, *Praying for Baby Rena: Religious Liberty, Medical Futility, and Miracles*, 25 SETON HALL L. REV. 960, 964–65 (1995) (quoting Weiser Part I, *supra* note 40, at A1).

⁷⁶ Weiser Part II, *supra* note 72, at A1.

⁷⁷ Smolin, *supra* note 75, at 966.

⁷⁸ *Id.*

⁷⁹ Kent Sepkowitz, *For Bobbi Kristina Brown, Science and the Miraculous Don’t Have to Be at Odds*, DAILY BEAST (Feb. 11, 2015), <http://www.thedailybeast.com/articles/2015/02/11/for-bobbi-kristina-brown-science-and-the-miraculous-don-t-have-to-be-at-odds.html?via=newsletter&source=DDAAfternoon>.

⁸⁰ *Family Continues Legal Battle to Have Brain-Dead Girl Declared Alive*, CBS NEWS (Dec. 24, 2015), <http://www.cbsnews.com/news/family-continues-legal-battle-to-have-brain-dead-girl-declared-alive/>.

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.*

actually went before a judge.⁸⁴ The judge ruled that the ventilator could be withdrawn if Jahi's family could not find an alternative facility that would provide her care.⁸⁵ Jahi's family received permission to remove Jahi from Oakland Children's Hospital, and as of December of 2015, Jahi's family was still caring for her in a "home environment" in New Jersey.⁸⁶ Jahi has remained on a ventilator for the last two years with no reported signs of improvement.⁸⁷

These cases represent very private moments that became heartbreaking public spectacles. But much more often, these end-of-life decisions are made by families and providers in the shadow of the media or courtrooms. The cases are not always so clear-cut, where the medical consensus is that the patient is brain-dead and care is absolutely futile. Sometimes, the medical team disagrees about whether the patient would survive withdrawal of mechanical ventilation, and whether she might eventually regain function that would be acceptable to her. While Baby Rena and Jahi's cases challenged futility standards on moral and religious grounds, the word futility may be challenged as well on scientific and empirical grounds. The term itself is a vexing one, but rather than stumble on its imprecision, I will employ it here to mean that additional care is contrary to acceptable standards of care as there is likely no meaningful benefit to the patient. This is an imperfect and fuzzy standard, but in many cases a workable one.

To address the very problem of families requesting that "everything be done,"⁸⁸ when the provider thinks that this care is medically inappropriate, the majority of states have passed medical futility statutes.⁸⁹ The typical medical futility statute prescribes either specific procedures or standards of conduct, and essentially provide immunity from civil or criminal liability for

⁸⁴ *Id.*

⁸⁵ Sergio Quintata, *Family In Talks with Facilities to Move Jahi McMath*, ABC NEWS (Dec. 19, 2013), <http://abc7news.com/archive/9374667/>.

⁸⁶ *Family Continues Legal Battle to Have Brain-Dead Girl Declared Alive*, *supra* note 80.

⁸⁷ *Id.*

⁸⁸ See SCHNEIDERMAN ET AL., *WRONG MEDICINE: DOCTORS, PATIENTS, AND FUTILE TREATMENT* 40 (Johns Hopkins Univ. Press ed., 1995) (describing implications of requests from patients and families seeking extreme treatments and calling for responsive legislative reform).

⁸⁹ See generally Pope, *supra* note 6.

providers who follow the statute when withdrawing futile care.⁹⁰ Some statutes do not specifically mention the term “futility,” and instead just indicate that if a provider chooses for reasons of “conscience” not to provide life-sustaining care, she can do so, but must first satisfy certain requirements.⁹¹

The futility standard is fuzzy because it assumes that there can be general agreement about prognosis. It is also fuzzy because religions provide different guidance on principles such as suffering, impermanence, the role of consciousness, and even the definition of death, which inevitably confuses any clinical standard of futility.⁹² Unfortunately, providers can never be absolutely certain that care is medically ineffective or futile, as patients rarely present in textbook ways. This uncertainty can lead to ambiguity in end-of-life care decision-making. An ideological tug-of-war may take hold between life-conservationists and resource-conservationists, or in other words, between the sympathetic providers and religious family members on one end, and providers who think resources are being wasted, or that the team is complicit in torture, on the other. While appeals to miracles are frequent, particularly on television, their occurrence is not.⁹³ Even if prognosticating is imperfect, there is usually agreement between physicians as to whether the care is futile. But even when the medical team and ethics committee are in agreement that the care is futile, the question looms large: how much time, if any, do we give the patient (and her family) to allow their God to intervene and perform a miracle?

Skeptical providers ask whether God needs a ventilator to perform his miracles, and why he might perform miracles for

⁹⁰ *Id.* at 58.

⁹¹ UTAH CODE ANN. § 75-2a-115 (West 2016).

⁹² Mohamed Y. Rady & Joseph L. Verheidje, *The Determination of Quality of Life and Medical Futility in Disorders of Consciousness: Reinterpreting the Moral Code of Islam*, 15 AM. J. BIOETHICS 14, 14 (2015) (discussing the effects of Islamic bioethics and principles of Westernization on determinations about medical futility); Tuck Wai Chan & Desley Hegney, *Buddhism and Medical Futility*, J. BIOETHICAL INQUIRY 434, 434 (2012) (explaining Buddhist ethical and religious implications of medical futility).

⁹³ Susan Diem et al., *Cardiopulmonary Resuscitation on Television: Miracles and Misinformation*, 334 NEW ENG. J. MED. 1578, 1580 (1996) (“The portrayal of miracles [on television] as relatively common events can undermine trust in doctors and data.”).

some devoted patients but not others.⁹⁴ Believers in miracles focus instead on whether it is right to limit God's potential to intervene by withdrawing life support prematurely, especially when the body is still warm and the heart is beating.⁹⁵ Either way, the two groups are talking past each other, as they employ different meanings of the words "miracle" and "futility" and certainly put different emphases on the cost of getting the decision wrong.

This paper will spend a good deal of time engaging with the constitutional and statutory requirements in this situation. Is there a legal requirement to provide ventilator support indefinitely while a family waits for a religious miracle? Even if the physician is protected from a complaint of medical malpractice, can the provider unilaterally withdraw support without violating religious free exercise?⁹⁶

II. THE LEGAL LANDSCAPE FOR WITHDRAWING CARE WHEN FAMILIES PRAY FOR A MIRACLE

Physicians overestimate the risk of being sued and this guides their day-to-day practice.⁹⁷ Even if the actual risk is low, the menacing specter of a lawsuit is very real, with its reputation-crushing and time-sucking gravity. Many providers report that the fear of liability is a chief reason they would give special consideration to a religious request for futile care.⁹⁸ Avoiding a lawsuit becomes paramount, even if professional ethics and justice warrant the cessation of aggressive treatments. Whether

⁹⁴ See generally Teneille Brown, *Accommodating Miracles* (Jan. 23, 2017) (unpublished manuscript) (on file with the First Amendment Law Review) [hereinafter Brown II].

⁹⁵ *Id.*

⁹⁶ The withdrawal is almost never *truly* unilateral, as the clinical team consults repeatedly with family, social workers, and others before aggressively advocating for removal of futile treatments. Even so, the term reflects that the provider may terminate treatments when the patient does not consent. See Cheryl J. Misak, Douglas B. White & Robert D. Truog, *Medical Futility: A New Look at an Old Problem*, 146 *CHEST* 1667, 1668 (2014) (reframing the futility discussion from the typical lens of a unilateral withdrawal, and instead suggesting that "[m]edical decisions are never made unilaterally . . . [but] are made in the context of an implicit and evolving social contract among patients, physicians, and societies at large.").

⁹⁷ Barbara Phillips-Bute, *Transparency and Disclosure of Medical Errors: It's the Right Thing to Do, So Why the Reluctance?*, 35 *CAMPBELL L. REV.* 333, 336 (2013); Emily Carrier et al, *Physicians' Fears of Malpractice Lawsuits Are Not Assuaged by Tort Reforms*, 29 *HEALTH AFFAIRS* 1585, 1585 (2010).

⁹⁸ Brown II, *supra* note 95, at 5.

defensive medicine is practiced out of fear of an actual lawsuit or just a visit from their General Counsel's office with an institutional reprimand, most providers want nothing to do with lawyers or their unwelcome questions.

And it is not as if the physicians' fears of litigation are baseless. There are several ways that patients or their family members might legally challenge a provider's unilateral decision to withdraw futile life-sustaining measures. The most obvious suit would allege that the providers' withdrawal of the ventilator or refusal to perform cardio-pulmonary resuscitation (or any other treatment) violates the professional standard of care. This could give rise to a civil tort suit for negligence against the provider (i.e., medical malpractice). Although most conflicts are resolved by giving patients a little, though not an indefinite, amount of time, some families persist in their denial about their loved one's likely recovery and insist on futile care.⁹⁹

The medical futility statutes described above were enacted to prevent this sort of scenario and offer peace of mind to physicians invoking futility. However, if the statute predicates the legal safe harbor on practicing according to the standard of care and in good faith, then this standard resembles an ordinary negligence case.¹⁰⁰ Put another way, the patient's family would argue that the medical futility statute does not shield the provider from tort liability because the withdrawal of care was not supported by good clinical judgment, or was not done in good faith, according to the existing professional standard. As Thaddeus Pope has argued, uncertainty over how juries would define the professional standard of care renders hollow the protection that medical futility statutes attempt to provide.¹⁰¹ However, the particular statutory immunity in cases of medical futility does send a strong signal to physicians that if the standard of care is not to provide treatment, they should be protected from a negligence claim.

Notably, malpractice tort suits are different from suits for temporary injunctions against the hospital. An immediate motion for an injunction does not argue that a tort has occurred,

⁹⁹ *Id.* at 9-10.

¹⁰⁰ See Pope, *supra* note 6, at 64.

¹⁰¹ See *id.* at 73-74.

but instead argues that a right will be imminently violated or something inequitable will result if the hospital is not stopped from withdrawing care *right now*. A tort suit, on the other hand, would be decided when it is too late to reverse the withdrawal. The plaintiff would just be compensated with money if she prevails on her own, or on her loved one's behalf.

The next type of liability could come by way of the criminal law. While providers may fear criminal liability, this is *exceedingly* unlikely.¹⁰² There is no state that criminally prohibits a provider from withdrawing care that is deemed medically ineffective or futile. It does not meet the criminal definition of a battery. It is not murder. It is not criminal neglect. As long as the providers are honest with the family about why they are withdrawing the care, there is no fraud. These types of lawsuits also would arise too late to enjoin the withdrawal of the care. While the fear of tort or criminal liability poses risks to providers, and will impact their decisions to unilaterally withdraw care, I will not be addressing these types of suits here.

A second type of claim would involve the surrogates suing for constitutional due process violations. Here, the family could assert that the (a) public hospital's policy of unilaterally withdrawing treatment, or (b) the medical futility statute itself violates their procedural due process rights under the Fourteenth Amendment.¹⁰³ This might have some success if the statute does not allow for fair and advanced notice to the patient and a judicial hearing.¹⁰⁴ The most process-oriented medical futility statute that was passed by Texas, the Texas Advance Directive Act (TADA), offers immunity from a civil or criminal lawsuit if the facility treating the patient follows specific notification, consultation, and documentation requirements.¹⁰⁵ The Children's Hospital of Boston has adopted an institutional policy that resembles the TADA.¹⁰⁶

¹⁰² *Id.* at 49 ("Unilateral decisions to stop LSMT have thus led to homicide charges and at least one conviction. Admittedly, health care providers are rarely convicted.").

¹⁰³ See Pope, *supra* note 6, at 76.

¹⁰⁴ *Id.*

¹⁰⁵ TEX. HEALTH & SAFETY CODE ANN. § 166.046 (West 2016).

¹⁰⁶ Robert Truog, *Counterpoint: The Texas Advance Directives Act is Ethically Flawed: Medical Futility Disputes Must Be Resolved by a Fair Process*, 136 CHEST 968, 968 (2009).

Specifically, under TADA, the provider must give the surrogate forty-eight hours' notice before holding a meeting of the hospital's ethics committee.¹⁰⁷ The ethics committee then reviews the provider's determination that the care is futile.¹⁰⁸ If the committee finds that the disputed treatment is medically inappropriate, the surrogate is given the committee's written decision, which is final and not appealable in any court.¹⁰⁹ The patient or surrogate can request an extension from withdrawal from a district or county court, which will be granted "only if the court finds, by a preponderance of the evidence, that there is a reasonable expectation that a physician or health care facility that will honor the patient's directive will be found if the time extension is granted."¹¹⁰ Conversely, under the Boston Children's policy, the hospital must "inform [the surrogate] of their legal right to seek a court order to *block* the hospital from taking this action."¹¹¹

Under TADA, the provider is required to continue providing the disputed care for 10 days,¹¹² and during this time the provider must make reasonable efforts to transfer the patient to another provider that will comply with the surrogate's requests.¹¹³ If the transfer cannot be made, then the provider may unilaterally withdraw treatment, even life-sustaining treatment, on the eleventh day.¹¹⁴ The TADA therefore gives a great deal of authority to the hospital ethics committee. This absolute deference is procedurally suspect given that the majority of members are likely employed by one of the parties to the conflict (the hospital) and are on a first-name basis with the providers.¹¹⁵

¹⁰⁷ TEX. HEALTH & SAFETY CODE ANN. § 166.046(b)(2) (West 2016).

¹⁰⁸ § 166.046(a).

¹⁰⁹ § 166.046(b)(4)(B).

¹¹⁰ § 166.046(g).

¹¹¹ Truog, *supra* note 106, at 968 (emphasis added).

¹¹² TEX. HEALTH & SAFETY CODE ANN. § 166.046(e) (West 2016).

¹¹³ § 166.046(d).

¹¹⁴ § 166.046(e).

¹¹⁵ "[Hospital Ethics Committees (HECs)] are overwhelmingly intramural bodies; that is, they are comprised of professionals employed directly or indirectly by the very same institution whose decision the HEC adjudicates. Consequently, many HECs make decisions that suffer from risks of corruption, bias, carelessness, and arbitrariness." Thaddeus Mason Pope, *Multi-Institutional Healthcare Ethics Committees: The Procedurally Fair Internal Dispute Resolution Mechanism*, 31 CAMPBELL L. REV. 257, 258 (2009).

The TADA, and laws like it, may very well be unconstitutional as a deprivation of a liberty interest without due process, as the required hearing may be inadequate and the decision-maker is not impartial.¹¹⁶

A substantive due process claim could be brought against any state actor who relied on a state law to deprive a patient of a fundamental liberty interest.¹¹⁷ Compared to the procedural due process claim, the Fourteenth Amendment's substantive due process claim is less likely to be successful. Following *Washington v. Glucksberg*,¹¹⁸ whichever "careful description" of the liberty interest one employs—whether it be to require a provider to continue care while the family prays for a religious miracle or to give families time to wait for a miracle in medical treatments—this liberty interest would not be found to be "deeply rooted in the history and tradition" of our nation.¹¹⁹ Because the ability to sustain life through the use of technologically advanced equipment did not exist in our country's early history, there is no case law support for the idea that demanding its use while a family prays for a miracle would be a fundamental liberty interest. Even if it were considered a fundamental liberty

¹¹⁶ See Nora O'Callaghan, *Dying for Due Process: The Unconstitutional Medical Futility Provision of the Texas Advance Directives Act*, 60 BAYLOR L. REV. 527, 585–89 (2008).

¹¹⁷ "If one were forced to find a common thread running through the cases in the privacy strand of modern substantive due process jurisprudence, it would likely be governmental non-interference in intimate, personal decisions, especially those regarding sexuality (e.g., *Griswold and Baird*), reproduction (e.g., *Roe v. Wade*) and marriage (e.g., *Loving v. Virginia*). Nevertheless, despite what for a while seemed like a trend of expanding the ambit of the right to privacy, and perhaps because of the controversy that some of these decisions engendered, especially with regard to abortion, the Supreme Court in recent years has been extremely reluctant to expand the scope of the privacy strand of substantive due process beyond those limits just discussed." See Jerry H. Elmer, *Physician-Assisted Suicide Controversy at the Intersection of Law and Medicine*, 46 R.I. BAR J. 13, 24 (1998).

¹¹⁸ 521 U.S. 702 (1997). The Supreme Court has made it very difficult to advance new "liberty interests." *Id.* at 720–21 (noting the Court's reluctance to expand the notion of substantive due process). The liberty interest must be carefully described, and its protection must be "'deeply rooted in this Nation's history and tradition,' and 'implicit in the concept of ordered liberty,' such that 'neither liberty nor justice would exist if they were sacrificed.'" *Id.* at 721 (plurality opinion) (citations omitted) (quoting *Moore v. E. Cleveland*, 431 U.S. 494, 503 (1977); then quoting *Palko v. Connecticut*, 302 U.S. 319, 325–26 (1937)). A right to demand that providers violate their professional standards and provide futile care so that the family can pray for a miracle would fail this test.

¹¹⁹ *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934) ("[S]o rooted in the traditions and conscience of our people as to be ranked as fundamental"); see also *Palko*, 302 U.S. at 325–26 ("[I]mplicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if they were sacrificed.").

interest, it could be infringed by the state with compelling interests that are narrowly tailored.¹²⁰ This strict scrutiny is similar to that found under the state and federal Religious Freedom Restoration Acts, and I will analyze this test thoroughly in section [x].

Despite the interesting questions these tort, criminal, and Fourteenth Amendment analyses pose, I have a fourth type of claim in my crosshairs. As I mentioned in the introduction, there is something about the religious request for futile care that makes providers more fastidious. They are particularly concerned about treading lightly on patients' religious freedoms, perhaps even more concerned than they are about deviating from the medical standard of care.¹²¹ I am therefore exploring in this article whether the provider or hospital is violating the patient's free exercise rights under the First Amendment, or their rights under the Religious Freedom Restoration Act of their state. I will evaluate why patients or their family members might make such a religious freedom claim, and its likelihood of success. I will analyze relevant case law developments related to religious exemptions for free exercise to determine whether there might be a violation of the patient's religious free exercise rights when providers unilaterally withdraw treatment. This liability would not attach to individual providers, and would be directed at the constitutionality of state laws and state institutional policies. I will also ask whether the federal or state Religious Freedom Restoration Acts (RFRAs) might provide an avenue for successful legal action.

A. Unilateral Withdrawal of Life-Sustaining Care Would Not Violate the First Amendment's Free Exercise Clause

¹²⁰ *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 871 (1992).

¹²¹ *Curlin et al.*, *supra* note 2, at 129 (“[P]rofessional attention to patients’ religious and spiritual concerns is one part of a broader movement toward a more patient-centered, culturally competent, narrative, and holistic medicine. This movement emphasizes the notion that patients interact with the health care system from a specific language, culture, community, and tradition, all of which shape patients’ decisions and experiences related to illness.”).

The First Amendment of the U.S. Constitution states, “Congress shall make no law respecting an establishment of religion, *or prohibiting the free exercise thereof*. . . .”¹²² The first part of this is called the “Establishment Clause,” and prohibits state endorsement of religion.¹²³ The second focuses on being free from government restraint to express religious beliefs and practices.¹²⁴ Historically, free exercise of religion was the right to act publicly on the choices of religious conscience.¹²⁵ James Madison wrote that religious practices must be protected from government interference because they are inseparable from religious beliefs, as religion consists of both “the duties that we owe to our Creator, and the manner of discharging them.”¹²⁶ However, as we will see, there is a “wide range of alternative content for the first amendment’s free exercise clause” and history, case law, and language have “left the clause open for widely disparate interpretation.”¹²⁷

Because many private actions could be swept up under the heading of religious exercise, its protection has never been unrestricted. While nearly every early state constitution guaranteed religious free exercise rights to some degree, they often specified that such exercise “not violate the public peace or the private rights of others.”¹²⁸ The early states usually narrowed their guarantee to “the free exercise of religious worship,” which meant that the protection of indirect forms of religious expression would need to be protected by other means, if at all.¹²⁹ In the United States, despite our history of being founded on religious freedom, states never went so far as to permit “encroaching on the rights of others, disturbing the public peace, or otherwise violating criminal laws” in order to protect it.¹³⁰

¹²² U.S. CONST. amend I (emphasis added).

¹²³ *See id.*

¹²⁴ *See id.*

¹²⁵ JOHN WITTE, JR. & JOEL NICHOLS, *RELIGION AND THE AMERICAN CONSTITUTIONAL EXPERIMENT* 45 (3d ed. 2011).

¹²⁶ *Id.*

¹²⁷ Stephen Pepper, *Taking the Free Exercise Clause Seriously*, 1986 BYU L. REV. 299, 299–300 (1986).

¹²⁸ Witte, Jr. & Nichols, *supra* note 125, at 46.

¹²⁹ *Id.*

¹³⁰ Luther Martin, *For the Federal Gazette: No. V*, FED GAZETTE & BALT. DAILY ADVERTISER, Mar. 19, 1799, at 2 (“The declaration, that religious faith shall be unpunished, does not give impunity to criminal acts, dictated by religious error.”).

With a few exceptions, this is the philosophy of religious freedom that has been endorsed by the U.S. Supreme Court.¹³¹ This explains how a civil right could be inherently viewed in a utilitarian framework, where the externalities of protecting religious freedom have never been ignored.

But before we engage too deeply in this First Amendment free exercise analysis, we need to explain exactly what form this claim would make in the context of medical futility. Importantly, only state actors can be found to violate the First Amendment, as the Constitution only prohibits *Congress* from making any law that would prohibit free exercise.¹³² This prohibition was extended to state governments through the Fourteenth Amendment, but does not reach private actors serving purely private interests.¹³³ Providers could be considered state actors if they serve a public function, such as working at the Veteran's Affairs hospitals, a state prison, a county-run clinic, or a public, state university hospital.

The state action needs to have deprived someone of a constitutional right, which here would be the freedom of religious exercise.¹³⁴ In medical futility cases, the patient's family would be arguing for an accommodation of their religious belief, through an exemption from the state or institution's medical futility law or policy. The patient's family would argue that complying with the policy would require a violation of the patient's religious beliefs of allowing God to act through prayer. There are not very many Supreme Court cases that deal precisely

¹³¹ Clark B. Lombardi, *Nineteenth-Century Free Exercise Jurisprudence and the Challenge of Polygamy: The Relevance of Nineteenth-Century Cases and Commentaries for Contemporary Debates About Free Exercise Exemptions*, 85 OR. L. REV. 374 (2006); Frederick Mark Gedicks & Rebecca G. Van Tassell, *RFRA Exemptions from the Contraception Mandate: An Unconstitutional Accommodation of Religion*, 49 HARV. C.R.-C.L. L. REV. 343 (2014).

¹³² Michael L. Wells, *Identifying State Actors in Constitutional Litigation: Reviving the Role of Substantive Context*, 26 CARDOZO L. REV. 99 (2004).

¹³³ In *West v. Atkins*, the Supreme Court held that a private physician under contract with the state to provide medical services at a state hospital is acting as a state actor for purposes of § 1983, a federal statute that allows plaintiffs to sue private individuals for civil rights violations. See 487 U.S. 42, 57 (1988).

¹³⁴ "Every exercise of judicial review should begin by identifying a governmental actor, a constitutional *subject*. And every constitutional holding should start by saying *who* has violated the Constitution." Nicholas Quinn Rosenkranz, *The Subjects of the Constitution*, 62 STAN. L. REV. 1209, 1214 (2010) (emphasis added) (citation omitted).

with religious freedom exemptions from a state or federal law, but these are the cases I will canvass.

Before determining that the patient should receive an exemption from a medical futility law, a court must first determine, as a threshold and definitional matter, whether the belief at issue is religious.¹³⁵ Then it must determine whether the belief is sincerely held.¹³⁶ In theory, the First Amendment does *not* allow questioning the empirical basis for the religious belief, but in practice, courts may dismiss First Amendment claims that are incredulous under either of these prongs.¹³⁷ In *United States v. Ballard*, the Court states that “[m]en may believe what they cannot prove. They may not be put to proof of their religious doctrines or beliefs.”¹³⁸ This means that even if a patient believes something unorthodox, while the sincerity of the belief may be questioned, the underlying religious belief cannot, so long as it passes the threshold test of stemming from a “religion.”¹³⁹

This broad deference to whether the belief is religious is true even if a patient’s beliefs are different from the beliefs of her co-members.¹⁴⁰ If a Muslim family believes in a type of miraculous religious intervention that would not be shared by most Muslims, this does not invalidate the First Amendment religious protection. The Court has reasoned that “it is not within

¹³⁵ “We refused to evaluate the objective reasonableness of the prisoner’s belief, holding that our ‘scrutiny extends only to whether a claimant sincerely holds a particular belief and whether the belief is religious in nature.’ *Ford v. McGinnis*, 352 F.3d 582, 590 (2d Cir. 2003); *see also*, *Tenaflly Eruv Ass’n, Inc. v. Borough of Tenaflly*, 309 F.3d 144, 171 (3d Cir. 2002), cert. denied, 539 U.S. 942.

¹³⁶ William P. Marshall, *In Defense of Smith and Free Exercise Revisionism*, 58 U. CHI. L. REV. 308, 310–11 (1991); *see* Kori Termine, *Ford v. McGinnis: Should Courts Really Enter the Thicket of Theology?* 24 QUINNIPIAC L. REV. 187, 194 (2005).

¹³⁷ “A court is more likely to find against a claimant on definitional grounds when the religion is bizarre, relative to the cultural norm, and is more likely to find that a religious belief is insincere when the belief in question is, by cultural norms, incredulous. The religious claims most likely to be recognized, therefore, are those that closely parallel or directly relate to the culture’s predominant religious traditions.” Marshall, *supra* note 137, at 311 (footnote omitted).

¹³⁸ 322 U.S. 78, 86 (1944).

¹³⁹ *Welsh v. United States*, 398 U.S. 333, 339–40 (1970) (adopting broad definition of “religion” under draft exemption statutes, but also influenced by constitutional concerns); *United States v. Seeger*, 380 U.S. 163, 176 (1965); *Frazee v. Ill. Dep’t of Emp’t Sec.*, 489 U.S. 829, 834 n.2 (1989) (noting that religious claims must be deemed genuine unless it is patently “bizarre or incredible”); *Lyng v. Nw. Indian Cemetery Protective Ass’n*, 485 U.S. 439, 457–58 (1988) (rejecting inquiry into “centrality” of belief or practice on ground that it involves second-guessing believer’s understanding of his religion).

¹⁴⁰ *Thomas v. Review Bd. of Ind. Emp’t Sec. Div.*, 450 U.S. 707, 716 (1981).

the judicial function and judicial competence to inquire whether the petitioner or his fellow worker more correctly perceived the commands of their common faith. Courts are not arbiters of scriptural interpretation.”¹⁴¹ Thus, for First Amendment purposes, it is irrelevant whether one Episcopalian holds beliefs about miracles that are not shared with other Episcopalians.

Importantly, the free exercise of “religion” need not be limited to obeying mandatory rules set down by a church. Although respected First Amendment scholar Doug Laycock recognizes that the rights implicated in free exercise are “at a maximum when government prohibits what faith unambiguously requires, or requires what faith prohibits,”¹⁴² he and others argue that the Free Exercise Clause must protect more than this.¹⁴³ The practice of religion encompasses more than following edicts, because otherwise it would fail to protect most religiously motivated practice. The ability to pray at a given location or be a member of the ministry are not requirements of each member of a faith, but they flow from religious belief. Thus, despite lower court rulings to the contrary, if a state law or regulation placed a substantial burden on the ability to pray, this would likely be considered a substantial burden on religious free exercise by the Supreme Court.¹⁴⁴

Despite this broad deference to how an individual conceives of her religious belief and religiously motivated conduct, the cases based on free exercise have generally not turned out favorably for people claiming that their rights have been violated.¹⁴⁵ As Ira Lupu points out, “[o]n rare occasions, application of these standards has produced important victories for religious freedom. Far more frequently, however, judges have

¹⁴¹ *Id.* at 716.

¹⁴² DOUGLAS LAYCOCK, RELIGIOUS LIBERTY, VOLUME 2: THE FREE EXERCISE CLAUSE 95 (John Witte Jr. ed., 2011).

¹⁴³ Frederick M. Gedicks, *Toward a Constitutional Jurisprudence of Religious Group Rights*, 1989 WIS. L. REV. 99, 142–44 (1989).

¹⁴⁴ *But see* Brandon v. Board of Education, 635 F.2d 971, 977 (2d Cir. 1980); Chess v. Widmar, 480 F. Supp. 907, 917 (W.D. Mo. 1979).

¹⁴⁵ While this dataset includes claims under the free exercise clause as well as RFRA and religiously motivated free speech claims, the plaintiffs’ success rate by two researchers was found to be 35.5%. Michael Heise & Gregory C. Sisk, *Free Exercise of Religion Before the Bench: Empirical Evidence from the Federal Courts*, 88 NOTRE DAME L. REV. 1371, 1387–88 (2013).

displayed pseudo-sensitivity to religious freedom.”¹⁴⁶ The next part of this article will investigate the development of the Supreme Court Free Exercise jurisprudence and how it supports this assertion.

B. The Development of Free Exercise Jurisprudence

In 1878, the Court decided *Reynolds v. United States*, the first free exercise case.¹⁴⁷ George Reynolds was a member of the Church of Jesus Christ of Latter-Day Saints (Mormons) who took a second wife and was charged under a criminal anti-bigamy statute.¹⁴⁸ George challenged the criminal statute on free exercise grounds.¹⁴⁹ The *Reynolds* Court held that bigamy could be considered a crime even though Mormons argued it was part of their religious rights, or even duties.¹⁵⁰ In this landmark free exercise case, the Court reasoned that the First Amendment protects religious belief but does not allow exemption from otherwise valid laws based on these religious beliefs.¹⁵¹ To permit an exemption for Reynolds “would be to make the professed doctrines of religious belief superior to the law of the land, and in effect to permit every citizen to become a law unto himself.”¹⁵² In so holding that the criminal anti-bigamy statute was valid, the Court said that “while [laws] cannot interfere with mere religious belief and opinions, they may with practices.”¹⁵³ This created a categorical prohibition on exemptions from generally applicable laws (i.e., laws that applied to religious and non-religious conduct alike). *Reynolds* has never been explicitly overruled, but its application *has* been limited.¹⁵⁴ For one, the distinction between religious belief and conduct that the *Reynolds* Court

¹⁴⁶ Ira C. Lupu, *Hobby Lobby and the Dubious Enterprise of Religious Exemptions*, 38 HARV. WOMEN’S L.J. 35, 39 (2015).

¹⁴⁷ 98 U.S. 145 (1878).

¹⁴⁸ *Id.* at 146.

¹⁴⁹ *Id.* at 162.

¹⁵⁰ *Id.* at 168.

¹⁵¹ *Id.*

¹⁵² *Id.* at 167.

¹⁵³ *Id.* at 166.

¹⁵⁴ “*Reynolds*, despite its age, has never been overruled by the United States Supreme Court and, in fact, has been cited by the Court with approval in several modern free exercise cases, signaling its continuing vitality.” *State v. Holm*, 2006 UT 31, ¶ 51 (2006); and for the limitations on the *Reynolds*’ holding, see, *Brown v. Buhman*, 947 F. Supp. 2d 1170, 1187 (D. Utah 2013), *vacated*, 822 F.3d 1151 (10th Cir. 2016).

endorsed has been disavowed.¹⁵⁵ The clause currently protects religious conduct as well as religious belief.¹⁵⁶ However, the general principle disfavoring exemptions from otherwise valid and generally applicable laws remains.¹⁵⁷

The Court made a rhetorical shift in 1961 from categorical prohibitions on exemption for generally applicable laws. Instead of categorically prohibiting them, the Court now discussed, and found relevant, the burdens imposed on the religious believer. In *Braunfeld v. Brown*,¹⁵⁸ Jewish shopkeepers argued for an exemption from enforcement of a Pennsylvania criminal statute, which prohibited shops from being open on Sundays.¹⁵⁹ The shopkeepers lost, but the Court nevertheless inquired into the burdens that would be imposed on religious practice by having to work on their Jewish Sabbath in order to stay competitive and comply with mandatory closures on the Christian Sabbath.¹⁶⁰ The Court also asked whether the legislature could draft alternative means of achieving the same legislative goals.¹⁶¹ Even though the religious exercise claim failed, this was an important rhetorical shift to consider the burdens of complying with a generally applicable law.

Two years later, the Supreme Court's decision in *Sherbert v. Verner*¹⁶² built upon the language from *Braunfeld*. In *Sherbert*, a Seventh-day Adventist Church member was denied

¹⁵⁵ "In deciding the [Yoder] case in favor of the Amish parents, the Court also rejected the state's asserted distinction between regulation of 'beliefs' and regulation of 'conduct.' The Court stated that in cases of this sort, 'belief and action cannot be neatly confined in logic-tight compartments.'" See Paula A. Monopoli, *Allocating the Costs of Parental Free Exercise: Striking a New Balance Between Sincere Religious Belief and a Child's Right to Medical Treatment*, 18 PEPP. L. REV. 319, 339 (1991).

¹⁵⁶ Kristen A. Berberick, *Marrying into Heaven: The Constitutionality of Polygamy Bans Under the Free Exercise Clause*, 44 WILLAMETTE L. REV. 105, 115–16 (2007).

¹⁵⁷ Smith, 494 U.S. 872

¹⁵⁸ 366 U.S. 599 (1961).

¹⁵⁹ *Id.* at 601–02 ("Appellants contend that the enforcement against them of the Pennsylvania statute will prohibit the free exercise of their religion because, due to the statute's compulsion to close on Sunday, appellants will suffer substantial economic loss, to the benefit of their non-Sabbatarian competitors, if appellants also continue their Sabbath observance by closing their businesses on Saturday. . .").

¹⁶⁰ *Id.* at 608–09.

¹⁶¹ *Id.* at 603 ("Concededly, appellants and all other persons who wish to work on Sunday will be burdened economically by the State's day of rest mandate . . ."); *id.* at 608 ("[W]e examined several suggested alternative means by which it was argued that the State might accomplish its secular goals without even remotely or incidentally affecting religious freedom.").

¹⁶² 374 U.S. 398 (1963).

unemployment benefits because she refused to accept available employment that required her to work on Saturday, the day of her Sabbath.¹⁶³ In administrative proceedings under the unemployment benefits statute, the tribunal found that the restriction upon her availability for Saturday work brought her within the provision disqualifying for benefits, because she failed, without good cause, to accept “suitable work when offered . . . by the employment office or the employer”¹⁶⁴ Here, the Supreme Court upheld her free exercise claim by applying strict scrutiny, a framework born of the First Amendment speech protections but maturing in other doctrines.¹⁶⁵

Specifically in *Sherbert*, the Court asked whether the generally applicable and facially neutral unemployment regulations imposed a burden on the free exercise of the appellant’s religion, and whether the regulations were necessary to satisfy a compelling state interest.¹⁶⁶ As to the first requirement, the Court easily found that the law burdened her religious exercise.¹⁶⁷ The Court stated that the benefits ruling “force[d] her to choose between following the precepts of her religion and forfeiting benefits, on the one hand, and abandoning one of the precepts of her religion in order to accept work, on the other hand.”¹⁶⁸ It reasoned that the government imposing such a choice burdens free exercise in the same way as fining her for Saturday worship.¹⁶⁹

Next, the Court asked whether the state’s regulations were the least restrictive possible to further a compelling state interest.¹⁷⁰ The Court answered in the negative, saying that “even if the possibility of spurious claims did threaten to dilute the [unemployment] fund and disrupt the scheduling of [Saturday] work, it would plainly be incumbent upon the appellees to

¹⁶³ *Id.* at 399–400.

¹⁶⁴ *Id.* at 401.

¹⁶⁵ Stephen A. Siegel, *The Origin of the Compelling State Interest Test and Strict Scrutiny*, 48 AM. J. LEGAL HIST. 355, 357 (2006).

¹⁶⁶ *Sherbert*, 374 U.S. at 403.

¹⁶⁷ *Id.*

¹⁶⁸ *Id.* at 404.

¹⁶⁹ *Id.*

¹⁷⁰ *Id.* at 407.

demonstrate that no alternative forms of regulation would combat such abuses without infringing First Amendment rights.”¹⁷¹ The appellees did not assert this interest before the state court, and even if they had, they failed to demonstrate that it was the least restrictive means possible.¹⁷²

Addressing whether the state’s interests could have been deemed compelling, had they been raised, the Court emphasized that “[o]nly the gravest abuses, endangering paramount interests” could justify burdening Sherbert’s religion.¹⁷³ Seeing no compelling asserted interests in denying benefits to Sherbert, the Court held that the Free Exercise clause had been violated.¹⁷⁴ *Sherbert* created a new constitutional standard for testing First Amendment Free Exercise cases that employed the strict scrutiny test from Fourteenth Amendment jurisprudence.¹⁷⁵ That is, Free Exercise cases now included an inquiry into the relative religious burdens on the claimant, and whether the advanced state interests in the law are compelling and the least restrictive possible.¹⁷⁶

For nearly three decades, the Court employed the *Sherbert* test to free exercise claims in many different contexts.¹⁷⁷ It has been said that during this time the Court was “too willing to create exceptions to the doctrine, and lower courts were too willing to find that free exercise rights were not burdened and that governmental interests were compelling.”¹⁷⁸ According to Douglas Laycock, during this time courts routinely underestimated the burdens imposed and overestimated the importance of governmental interests.¹⁷⁹ Even so, the test remained and the Court continued to inquire into the religious burdens imposed by religiously neutral laws.¹⁸⁰ The next

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ *Id.* at 406 (quoting *Thomas v. Collins*, 323 U.S. 516, 530 (1945)).

¹⁷⁴ *Id.* at 409–410.

¹⁷⁵ *Id.* at 403.

¹⁷⁶ *Id.*

¹⁷⁷ LAYCOCK, *supra* note 142, at 393.

¹⁷⁸ *Id.* at 393.

¹⁷⁹ *Id.* at 394.

¹⁸⁰ *See id.*

landmark case to employ *Sherbert* was *Wisconsin v. Yoder*, decided in 1972.¹⁸¹

In *Yoder*, members of the Amish religion were convicted of violating Wisconsin's compulsory school attendance law.¹⁸² Instead of attending school until the age of sixteen, as the law required, the Amish provided their own vocational education after the eighth grade.¹⁸³

The Court in *Yoder* held that the Free Exercise Clause relieved adult members of the "Old Order Amish" from the obligation to send their children to school until the age of sixteen.¹⁸⁴ The Court argued that respondents have amply supported their claim "that enforcement of the compulsory formal education requirement after the eighth grade would gravely endanger if not destroy the free exercise of their religious beliefs."¹⁸⁵ Complying with Wisconsin's law would mean that the members would receive not only the "censure of the church community," but would also "endanger their own salvation and that of their children."¹⁸⁶ This presented a significant burden on their religious free exercise.¹⁸⁷

The Court also found that the state interest was not compelling.¹⁸⁸ This was not as applied generally to the state's interest in public education, but in the specific state interest in requiring public education until the age of sixteen for the Amish in this case.¹⁸⁹ The Amish experts testified at trial, without challenge, that a few extra years of compulsory education

may be necessary when its goal is the preparation of the child for life in modern society as the majority live, but it is quite another if the goal of education be viewed as the preparation of the child

¹⁸¹ 406 U.S. 205 (1972).

¹⁸² *Id.*

¹⁸³ *Id.* at 205.

¹⁸⁴ *Id.* at 234–35.

¹⁸⁵ *Id.* at 205.

¹⁸⁶ *Id.* at 209.

¹⁸⁷ *Yoder*, at 220–21.

¹⁸⁸ *Id.* at 222.

¹⁸⁹ *Id.* at 221.

for life in the separated agrarian community that is the keystone of the Amish faith.¹⁹⁰

Moreover, the Amish provided an “ideal vocational education for their children in the adolescent years,” in case they should choose to leave the faith.¹⁹¹

Like *Sherbert*, *Yoder* also used the language of “burdening” the believers and requiring “compelling” state interests, and seems to perform a cost-benefit analysis that stacks up the net benefits and burdens to the claimants and the state.¹⁹² The Court ruled in favor of the Amish, but only after a thorough assessment of the impact of the exemption on the state and the religious believers.¹⁹³ Notably, the Court seemed impressed by the historical roots of the Amish people’s religious requests, and the fact that this was a sincere and deeply held belief that was integral to their religious faith.¹⁹⁴ Future cases would challenge the relevance of this finding of sincerity and centrality, but this *dicta* raises interesting questions for medical futility cases that will be discussed later in the article. *Yoder* remained the high-water mark in terms of protecting religious liberties well into the 1980s.¹⁹⁵ After this case, the Supreme Court retreated, and there were very few victories for Free Exercise claimants.¹⁹⁶ Those who did succeed demonstrated explicit discrimination against religion or denials of unemployment compensation, as in *Sherbert*.¹⁹⁷

¹⁹⁰ *Id.* at 222.

¹⁹¹ *Id.* at 224.

¹⁹² *Id.* at 229.

¹⁹³ *Id.* at 236.

¹⁹⁴ *Id.* at 205 (“Aided by a history of three centuries as an identifiable religious sect and a long history as a successful and self-sufficient segment of American society, the Amish have demonstrated the sincerity of their religious beliefs, the interrelationship of belief with their mode of life, the vital role that belief and daily conduct play in the continuing survival of Old Order Amish communities, and the hazards presented by the State’s enforcement of a statute generally valid as to others.”).

¹⁹⁵ See Steven H. Aden & Lee J. Strang, *When A “Rule” Doesn’t Rule: The Failure of the Oregon Employment Division v. Smith “Hybrid Rights Exception”*, 108 PENN ST. L. REV. 573, 577 (2003) (“Wisconsin v. Yoder was, in many ways, the high water mark of free exercise mandated exemptions.”).

¹⁹⁶ “While the Court continually rejected the claims of free exercise plaintiffs, it continued to invoke the language of the compelling state interest test. It thus appeared that the Supreme Court had settled on applying a watered-down version of strict scrutiny in the area of free exercise.” See *id.* at 579.

¹⁹⁷ Arnold H. Loewy, *Rethinking Free Exercise of Religion After Smith and Boerne: Charting a Middle Course*, 68 MISS. L.J. 105 n.44 (1998); Daniel A. Crane, *Beyond RFRA: Free Exercise of Religion Comes of Age in the State Courts*, 10 ST. THOMAS L. REV. 235, 246 (1998) (“Putting aside the unemployment compensation cases, not since

This then brings us to the case of *Department of Human Resources v. Smith*.¹⁹⁸ This case changed everything.¹⁹⁹ In this case, petitioners were fired from their jobs at a private drug rehabilitation center for ingesting peyote for sacramental purposes at a ceremony of their Native American church.²⁰⁰ They sought review of the denial of their unemployment benefits, claiming that their use of the hallucinogen peyote should not have been considered criminal misconduct, making them ineligible for benefits.²⁰¹ Justice Scalia wrote the plurality opinion, which found that their free exercise rights had *not* been violated.²⁰² The Court held that to grant an exemption from a religiously-neutral law would place the employees “beyond the reach of a criminal law that is not specifically directed at their religious practice. . . .”²⁰³ Justice Scalia went on to say that the collection of a general tax might offend the religious freedom of those who do not believe in supporting organized government, but they would still be required to pay the tax.²⁰⁴ If burdening religion “is not the object of the tax, but merely the incidental effect of a generally applicable and otherwise valid provision, the First Amendment has not been offended.”²⁰⁵ Heretofore, indirect burdens on religious practices that apply equally to the religious and non-religious would not be considered violations of the First Amendment’s free exercise clause.

The plurality opinion dismantled the *Sherbert* test, which had required demonstrating that a law that substantially burdened religion be the least restrictive necessary to fulfill a compelling state interest. Justice Scalia noted that “[i]n recent years we have abstained from applying the *Sherbert* test (outside the unemployment compensation field) at all” and he then listed many different cases where the Court did not require the

Yoder had the Supreme Court required an exemption from a generally applicable law on free exercise grounds.”).

¹⁹⁸ *Emp’t Div., Dep’t. of Human Res. v. Smith*, 494 U.S. 872 (1990).

¹⁹⁹ *See Aden & Strang*, *supra* note 195.

²⁰⁰ *See Smith*, 494 U.S. at 872.

²⁰¹ *Id.* at 872.

²⁰² *Id.* at 874.

²⁰³ *Id.* at 878.

²⁰⁴ *Id.*

²⁰⁵ *Id.*

government to advance a compelling state interest.²⁰⁶ The Court therefore argued that even if they were to apply it to the present case, they would not use it to require a religious exemption from an otherwise neutral and generally applicable law.²⁰⁷ In strong terms, the Court stated that it has “never held that an individual’s religious beliefs excuse him from compliance with an otherwise valid law prohibiting conduct that the State is free to regulate.”²⁰⁸ The scrutinizing framework of *Sherbert* and *Yoder* were being completely undone.

1. Applying Current First Amendment Free Exercise Precedent to Medical Futility Statutes

So long as *Smith* holds, it is exceedingly unlikely that existing medical futility statutes could be found to violate a patient’s First Amendment Free Exercise of religion. While not technically required by any religious faith, belief in the power of prayer to heal the sick is motivated by religion and the free exercise protections ought to apply. The threshold finding that the statutes impact the practice of religion should be met. Courts might disagree on whether the statutes place a substantial burden on religion. Because this component mirrors the analysis under the federal and state Religious Freedom Restoration Acts (RFRA), this prong will be examined in the next subsection of the Article.

Smith holds that for First Amendment purposes, a generally applicable law will not violate free exercise if it is at least related to legitimate government interests.²⁰⁹ The unilateral withdrawal of futile treatment that is permitted under the futility statutes applies generally to religious patients and non-religious patients alike.²¹⁰ The medical futility statutes are thus neutral

²⁰⁶ *Id.* at 883–84.

²⁰⁷ “Even if we were inclined to breathe into *Sherbert* some life beyond the unemployment compensation field, we would not apply it to require exemptions from a generally applicable criminal law.” *Id.* at 884, *superseded by statute*, Religious Freedom Restoration Act of 1993, Pub. L. No. 103-141, 107 Stat. 1488 (November 16, 1993), codified at 42 U.S.C. § 2000bb through 42 U.S.C. § 2000bb-4.

²⁰⁸ *Id.* at 878–79.

²⁰⁹ *Id.* at 884.

²¹⁰ *See, e.g.*, ALASKA STAT. §13.52.060 (West 2016); CAL. PROB. CODE §§ 4735, 4736 (West 2016); DEL. CODE ANN. tit. 16, § 2508 (West 2016); HAW. REV. STAT. § 327E-7 (West 2016); ME. REV. STAT. ANN. tit. 18-A, §5-807 (West 2016); MISS. CODE

laws that do not mention religious beliefs as a basis for withdrawal or continuance of care. While some requests for futile care might be religiously motivated, many requests have nothing to do with religion at all. And as *Smith* declared, even if the religiously-neutral medical futility statutes incidentally burden the exercise of religion, these will not be invalidated under the First Amendment's Free Exercise Clause. Prior to *Smith*, the relative burdens on religion and benefits to the state would need to be assessed for First Amendment purposes.²¹¹ The state would have had to show that its interests in passing the medical futility statutes were compelling.²¹² After *Smith*, however, the challenge is much easier to overcome. The generally applicable and facially neutral medical futility statutes would not be considered unconstitutional.

However, as much of the preceding case analysis probably made clear, in a medical futility case the plaintiffs' claims would be even *weaker* than for those decided by the Supreme Court in the past. In *Smith*, *Yoder*, and *Braunfeld*, the plaintiffs were not arguing that they should be able to require some third party to act. Rather, they were arguing that they should be exempt from legal sanctions for acting (or not acting) themselves. This is a very important difference, which spells unlikely success for a religious patient praying for a miracle.

In the case of a challenge to a medical futility statute, the religious challengers would be seeking medically futile care, which would require the conscription of objecting hospital staff who may or may not be state actors, as well as the use of insurance resources to cover the oversight and use of the medical equipment in a way that might violate the clinical standard of care. Even under an analysis akin to that which the *Sherbert* or *Yoder* court undertook, it is quite unlikely religious patients would prevail given the moral and economic costs imposed on

ANN. § 41-41-215 (West 2016); N.J. STAT. ANN. §§ 26:2H-62, 26:2H:65 (West 2016); N.M. STAT. ANN. § 24-7A-7 (West 2016); TENN. CODE ANN. § 68-11-1808 (West 2016); TEX. HEALTH & SAFETY CODE ANN. § 166.046 (West 2016); WYO. STAT. ANN. § 35-22-408 (West 2016).

²¹¹ *Sherbert v. Verner*, 374 U.S. 398, 404 (1963).

²¹² *Id.* at 406.

third-parties.²¹³ As Frederick Gedicks and Rebecca G. Van Tassel point out, permissive accommodations under the Free Exercise Clause may violate the Establishment Clause when they externalize the cost of protecting religious freedom to non-believing third-parties such as private hospitals and their staff.²¹⁴ Unlike permissive religious accommodations that may be allowed by patients or providers, the structural bars on establishing religion cannot be waived by patients, providers, or the hospital staff.²¹⁵ Thus, to the extent that medical futility statutes or policies carve out religious reasons for special treatment to protect free exercise, the cost-shifting to non-believing third-parties (patients who do not receive ventilator support because they are being used by religious patients, or providers who morally object to providing this care) could then violate the Establishment Clause.²¹⁶

Additionally, the net burdens and benefits skew sharply against the hospital and insurance company, making the accommodation less permissible. The denial of extra time to wait for a miracle may indirectly burden religious practice, but the significance of this burden is hard to quantify. In a medical futility case, the patient's family is never prohibited from praying for a miracle, they are just prohibited from *requiring the providers to perform certain tasks* while they pray for a miracle.²¹⁷ However, if we are to give any independent content to the idea of a "substantive burden," the likelihood of the outcome of the religious exercise must matter as well as the magnitude of what

²¹³ Gedicks & Van Tassel, *supra* note 131, at 349 ("[T]he Court condemns permissive accommodations on Establishment Clause grounds when the accommodations impose significant burdens on third parties who do not believe or participate in the accommodated practice.").

²¹⁴ *Id.*

²¹⁵ *Id.* at 347 ("[T]he Establishment Clause is a structural bar on government action rather than a guarantee of personal rights. Violations of the Establishment Clause cannot be waived by the parties or balanced away by weightier private or government interests, as can violations of the Free Exercise Clause.").

²¹⁶ See Gedicks & Van Tassel, *supra* note 132, at 357 ("[These] decisions demonstrate the Court's general rejection of accommodations that shift the costs of accommodating a religion from those who practice it to those who don't.").

²¹⁷ For example, the Texas medical futility statute provides that "[t]he attending physician, any other physician responsible for the care of the patient, and the health care facility are not obligated to provide life-sustaining treatment after the 10th day after both the written decision and the patient's medical record required under Subsection (b) are provided to the patient or the person responsible for the health care decisions of the patient", but there is no mention of any prohibition on the patient's ability to pray during this procedure. TEX. HEALTH & SAFETY CODE ANN. § 166.046 (West 2016).

is lost by no accommodation. If hospitals recognized religious exemptions for those demanding futile care, there may be no limit to the requests. Hospitals would run out of space and equipment. This would be exacerbated by the difficulty discerning the sincere religious requests from the insincere, a topic we will take up later in the Article.²¹⁸

2. The Response to *Smith* – the Federal Religious Freedom Restoration Act (RFRA)

Academics, politicians, religious leaders, and the media were quick to condemn the *Smith* opinion.²¹⁹ Three prominent First Amendment scholars described the decision as a “sweeping disaster for religious liberty” while Congressman Stephen J. Solarz declared that “the Supreme Court has virtually removed religious freedom from the Bill of Rights.”²²⁰ Congress responded to the *Smith* decision by passing the Religious Freedom Restoration Act (RFRA) three years later in 1993.²²¹ Supported by a diverse coalition of members of Congress and signed into law by President Clinton, RFRA reintroduced the compelling interest test as a statutory right.²²² More precisely, the goal of RFRA was to prevent governments at all levels (local, state, and federal) from substantially burdening Free Exercise rights with generally applicable laws unless the government satisfied strict scrutiny, that is, the law was the least restrictive possible to further a compelling state interest.²²³

²¹⁸ Thomas C. Berg, *What Hath Congress Wrought? An Interpretive Guide to the Religious Freedom Restoration Act*, 39 VILL. L. REV. 1, 41 (1994) (“In a few cases, however, a claimed exemption, though tolerable on its own, raises a strong risk of bringing on many others, and so poses ‘a substantial threat to public safety or order . . . sometimes granting an exemption will produce ‘an administrative problem of such magnitude’ as to ‘render the entire statutory scheme unworkable.’ . . . The threat of cumulative exemptions comes not only from other sincere religious objectors, but from other persons who could feign the same objection to get the benefits of exemption. The First Amendment itself hampers the government in uncovering such ‘strategic behavior,’ because the government cannot adopt too narrow a definition of what beliefs or practices are ‘religious’ or inquire too closely into their sincerity or their importance to the believer.”).

²¹⁹ See James E. Ryan, *Smith and the Religious Freedom Restoration Act: An Iconoclastic Assessment*, 78 VA. L. REV. 1407 (1992) (“Members of the media, academics, members of Congress, and religious interest groups greeted the decision with condemnation and despair.”).

²²⁰ *Id.* at 1409–10.

²²¹ Michael Heise & Gregory C. Sisk, *Free Exercise of Religion Before the Bench: Empirical Evidence from the Federal Courts*, 88 NOTRE DAME L. REV. 1371, 1373 (2013).

²²² *Id.*

²²³ 42 U.S.C.A. § 2000bb-1 (West 2016).

Through RFRA, Congress sought to undo the consequences of the Court's *Smith* decision and restore a statutory standard that was more protective of religious freedom.²²⁴ Though many others have advanced this argument, the fact that RFRA was never successfully challenged on Establishment Clause grounds is perplexing.²²⁵ However, the Supreme Court has interpreted the statute and has not deemed it unconstitutional, at least as applied to federal government action.²²⁶ In fact, in *Gonzales v. O Centro*, the Supreme Court validated a “focused” read of RFRA that *heightened* the burden on the federal government.²²⁷

The Supreme Court did find that RFRA had overstepped its bounds as it applied to the states. In *City of Boerne v. Flores*, the Court announced that Congress exceeded its Fourteenth Amendment authority by enacting legislation designed to enforce the Free Exercise Clause against the states.²²⁸ In so doing, the Court declared that RFRA cannot be applied to the states.²²⁹ However, while it left undecided whether RFRA is also unconstitutional at the federal level, subsequent case law has apparently decided this in the negative.²³⁰

The *Boerne* case has a significant impact on Free Exercise claims, as only a fraction of laws that burden religious exercise

²²⁴ Heise & Sisk, *supra* note 221, at 1373.

²²⁵ Christopher L. Eisgruber & Lawrence G. Sager, *Why the Religious Freedom Restoration Act Is Unconstitutional*, 69 N.Y.U. L. REV. 437, 453 (1994) (“Supreme Court decisions make clear that the constitutional power to accommodate religious practice does not license the state to confer privileges upon religious believers indiscriminately.”); see Scott C. Idleman, *The Religious Freedom Restoration Act: Pushing the Limits of Legislative Power*, 73 TEX. L. REV. 247, 285–86 (1994); see also Frederick Mark Gedicks & Andrew Koppelman, *Invisible Women: Why an Exemption for Hobby Lobby Would Violate the Establishment Clause*, 67 VAND. L. REV. EN BANC 51, 54 (2014).

²²⁶ See *Burwell v. Hobby Lobby Stores, Inc.*, 134 S.Ct. 2751 (2014).

²²⁷ *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418, 419–20 (2006) (“[T]he Government [must] demonstrate that the compelling interest test is satisfied through application of the challenged law ‘to the person’—the particular claimant whose sincere exercise of religion is being substantially burdened.”).

²²⁸ 521 U.S. 507, 508 (1997) (“Although Congress certainly can enact legislation enforcing the constitutional right to the free exercise of religion . . . its §5 power ‘to enforce’ is only preventive or ‘remedial,’ . . . The Amendment’s design and § 5’s text are inconsistent with any suggestion that Congress has the power to decree the substance of the Amendment’s restrictions on the States.”) (citations omitted).

²²⁹ *Id.* at 534–535.

²³⁰ Aurora R. Bearse, *RFRA: Is It Necessary? Is It Proper?*, 50 RUTGERS L. REV. 1045, 1045 n.4 (1998).

are federal ones. Most religious liberty disputes arise over state and local laws.²³¹ This is the case with medical futility statutes and unilateral decisions to withdraw treatment. The statutes are passed and implemented at the state level, and so the federal RFRA would not apply. This puts a sharp halt to any federal RFRA analysis.

a. The Response to Boerne—state RFRAs

In the aftermath of *Boerne*, RFRA supporters began lobbying in their state capitals for state versions of the federal law.²³² Within just a few years, RFRA legislation had been proposed in several states.²³³ Advocacy groups that were traditionally considered at odds with one another came together to marshal RFRA through state legislatures, and “[t]he results generally rewarded their efforts.”²³⁴

These state RFRAs have now been passed by 21 states and Congress.²³⁵ The state acts are modeled on the federal law, requiring strict scrutiny when a state law burdens the exercise of religion.²³⁶ There are significant differences between states in terms of the threshold burden on religion that is required and whether there are areas where the law does not apply. Regardless of the differences, however, the *Smith* case remains the constitutional floor for protecting free exercise under the First Amendment.²³⁷ States are allowed to create greater protections, which most of the RFRAs do, but they cannot protect religious

²³¹ Christopher C. Lund, *Religious Liberty After Gonzales: A Look at State RFRAs*, 55 S.D. L. REV. 466, 467 (2010).

²³² James A. Hanson, *Missouri's Religious Freedom Restoration Act: A New Approach to the Cause of Conscience*, 69 MO. L. REV. 853, 856 (2004).

²³³ See Jason Goldman, *Religious Freedom: Why States Are Unconstitutionally Burdening Their Own Citizens As They "Lower" the Burden*, 2015 CARDOZO L. REV. DE NOVO 57, 60–61 (2015).

²³⁴ Hanson, *supra* note 232, at 856.

²³⁵ See 2015 *State Religious Freedom Restoration Legislation*, NATIONAL CONFERENCE ON STATE LEGISLATORS, <http://www.ncsl.org/research/civil-and-criminal-justice/2015-state-rfra-legislation.aspx> (“Seventeen states have introduced legislation this year regarding the creation of, or alteration to, a state religious freedom law. Currently, 21 states have Religious Freedom Restoration Acts (RFRAs).”); see also 42 U.S.C. ch. 21B (West 2016) (Congress passed RFRA in 1993).

²³⁶ See Mark Strasser, *Old Wine, Old Bottles, and Not Very New Corks: On State RFRAs and Free Exercise Jurisprudence*, 34 ST. LOUIS U. PUB. L. REV. 335, 358 (2015).

²³⁷ Lund, *supra* note 231, at 493.

free exercise less than *Smith* (i.e., permitting intentional religious discrimination).²³⁸

State courts have struggled to interpret state RFRA.²³⁹ Quite puzzlingly, some state courts have equated the strict scrutiny standard from their RFRA with the watered-down scrutiny of *Smith*, and others have interpreted their RFRA to provide less protection than *Smith*.²⁴⁰ Religious liberty claims should be analyzed differently under the First Amendment's Free Exercise Clause and RFRA. This is because Supreme Court jurisprudence controls Free Exercise claims, while statutory interpretation applies to state RFRA claims.²⁴¹ What the state RFRA has in common, however, is a requirement that the burden on religion be motivated by compelling state interests, as opposed to mere legitimate ones.

To invoke most state RFRA, the plaintiff needs to show that the governmental action placed a "substantial burden" on the plaintiff's exercise of a sincere religious belief.²⁴² If this threshold requirement is not met, then no claim or defense is available under many RFRA.²⁴³ Because the state interest in the law must only be narrowly tailored to further a compelling state interest if religion is found to be burdened, the threshold definition of "burden" under the state RFRA is quite important.

Some states (such as Alabama, Connecticut, Florida, Illinois, New Mexico, Rhode Island, South Carolina, and Texas) have not included a statutory definition of "substantial burden" in their RFRA, leaving the courts to define this term.²⁴⁴ Four state legislatures provided their understanding of what the term should mean.²⁴⁵ Arizona's definition appears the broadest, as it states "the term substantially burden is intended solely to ensure

²³⁸ See Michael D. Currie, *Scrutiny Mutiny: Why the Iowa Supreme Court Should Reject Employment Division v. Smith and Adopt A Strict Scrutiny Standard for Free-Exercise Claims Arising Under the Iowa Constitution*, 99 IOWA L. REV. 1363, 1377 (2014); see also Lund, *supra* note 231, at 466.

²³⁹ Lund, *supra* note 231, at 485–86.

²⁴⁰ *Id.* at 486.

²⁴¹ Hanson, *supra* note 232, at 857.

²⁴² Lund, *supra* note 232, at 477.

²⁴³ *Id.*

²⁴⁴ James W. Wright, Jr., *Making State Religious Freedom Restoration Amendments Effective*, 61 ALA. L. REV. 425, 433 (2010).

²⁴⁵ *Id.*

that this article is not triggered by trivial, technical or de minimis infractions.”²⁴⁶ Idaho and Oklahoma’s RFRA’s state that to substantially burden religious exercise is merely to “inhibit or curtail religiously motivated practices.”²⁴⁷ Pennsylvania’s statutory definition is the most detailed, and includes any act that:

- (1) Significantly constrains or inhibits conduct or expression mandated by a person's sincerely held religious beliefs.
- (2) Significantly curtails a person's ability to express adherence to the person's religious faith.
- (3) Denies a person a reasonable opportunity to engage in activities which are fundamental to the person's religion.
- (4) Compels conduct or expression which violates a specific tenet of a person's religious faith.²⁴⁸

Now, let us apply this detailed definition to the medical futility case at hand. One characterization of the burden could be that state RFRA medical futility statutes *impose no substantial burden on religious exercise*. At any point in the patient’s life, the family can pray for a miracle. No state medical futility law prohibits prayer. The question in these potential cases is whether the family should be allowed to pray under a specific set of conditions—namely, while the patient is being supported by artificial life support. No Supreme Court or RFRA case supports this expansive of a view of religious liberty, as this certainly “encroaches” on the rights of others; namely, the rights of the providers not to be required to provide futile care at the expense of other patients who might need their services.²⁴⁹

²⁴⁶ ARIZ. REV. STAT. ANN. § 41-1493.01(e) (West 2016).

²⁴⁷ Wright, Jr., *supra* note 244, at 434.

²⁴⁸ 71 P.S. § 2403 (West 2016).

²⁴⁹ See Kathleen M. Boozang, *Deciding the Fate of Religious Hospitals in the Emerging Health Care Market*, 31 Hous. L. Rev. 1429, 1481–1482 (1995) (“When initially enacted, the Conscience Clauses protected recipients of federal funds and their staffs from being required to participate in abortion or sterilization procedures that conflicted with the providers’ religious or moral beliefs. One year later, Congress expanded the Conscience Clauses to permit a health care provider to refuse to perform any health service or research that conflicts with personal religious or moral beliefs.”); see also Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. OF LEGAL MED. 177, 177 (1993); see also 42 U.S.C. 300a-7(d) (2000).

However, under a few state RFRA's, the denial of additional time to pray for a miracle might meet the threshold statutory definition of "burden."²⁵⁰ Specifically, under Idaho or Oklahoma's RFRA's, the denial of life support while the patient prays for a miracle could be said to "inhibit or curtail religiously motivated practices," such as praying for a miracle. Under Arizona's definition of a burden, the denial of life support while the patient or his family prays for a miracle would also likely not be considered a trivial infraction of religious free exercise, given that these are often life and death situations of tremendous spiritual and religious significance. In these states where it *could* be found that the denial of futile treatment results in a burden of religious exercise, the state would then need to demonstrate that the medical futility laws are narrowly tailored to advance a compelling state interest.²⁵¹

b. Multiple Compelling State Interests Exist to Deny Religious Exemptions from Medical Futility Laws

Although the states employ different thresholds for what counts as a sufficient burden, each requires that the state advance a compelling interest in the legislation.²⁵² When determining whether a state's interest is compelling, the courts in most states have said they look to First Amendment jurisprudence.²⁵³ Thus, the compelling interest inquiry would resemble that under the *Smith* and pre-*Smith* decisions, discussed above.

What is the compelling state interest in medical futility laws? There are several state interests that would likely be considered compelling, if the state or federal courts correctly interpreted existing strict scrutiny standards from *Sherbert* and other constitutional precedents. While "only those interests of the highest order and those not otherwise served can overbalance legitimate claims to the free exercise of religion[,]"²⁵⁴ the medical futility statutes could rather easily clear this hurdle. The states'

²⁵⁰ See Goldman, *supra* note 233, at 69 (describing the different conceptions of "burden" under state RFRA's).

²⁵¹ Alan E. Brownstein, *State RFRA Statutes and Freedom of Speech*, 32 U.C. DAVIS L. REV. 605, 627–28 (1999).

²⁵² Christopher C. Lund, *Religious Liberty After Gonzales: A Look at State RFRA's*, 55 S.D. L. REV. 466, 478 (2010).

²⁵³ *Id.*

²⁵⁴ *Wisconsin v. Yoder*, 406 U.S. 205, 215 (1972).

compelling interests in prohibiting religious exemptions from medical futility statutes could be:

- 1) respecting provider autonomy,
- 2) respecting physician's professional ethics and integrity by blurring the line between healing and harming,
- 3) not allowing professional standards of care to be trumped by religious requests,
- 4) preserving scarce resources in the event of an epidemic or other public health need,
- 5) the inability to distinguish the potentially abundant religiously insincere from sincere claims, and/or
- 6) the need for some principled and generally-applicable basis for terminating potentially indefinite life support.

Any of these could satisfy strict scrutiny, and some already have.²⁵⁵ For starters, both Congress and the Supreme Court have recognized the need to protect the autonomy, religious beliefs, and professional standards of health care providers.²⁵⁶ Physicians should not be required to perform treatments that run afoul of their conscience or professional ethics, just because a patient or his family is requesting it.²⁵⁷

The Church Amendment, which was passed by Congress in 1973, made clear that the receipt of federal Medicare funds would not provide a basis for mandating a health care provider "to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to

²⁵⁵ See *infra* pp. 42–50.

²⁵⁶ See *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997); see also *United States v. Lachman*, 48 F.3d at 586, 592–593;93 (1st Cir. 1995); *In re Quinlan*, 355 A.2d 647, 70 N.J. 10, 44 (1976) *overruled by* *Matter of Conroy*, 98 N.J. 321 (1985); Dennies Varughese, *Conscience Misbranded!: Introducing the Performer v. Facilitator Model for Determining the Suitability of Including Pharmacists Within Conscience Clause Legislation*, 79 TEMP. L. REV. 649, 659 (2006).

²⁵⁷ See Judith F. Daar, *A Clash at the Bedside: Patient Autonomy v. A Physician's Professional Conscience*, 44 HASTINGS L.J. 1241, 1260 (1993) ("While concern for a physician compromising his or her own concept of professional integrity may seem to have no place in the world of patient autonomy, in fact both courts and legislatures have historically regarded a physician's comfort with his or her actions as a high priority.").

his religious beliefs or moral convictions.”²⁵⁸ It also provided that no “entity” could be compelled to “make its facilities available for the performance of any sterilization procedure or abortion if [such] performance . . . is prohibited by the entity on the basis of religious beliefs or moral convictions.”²⁵⁹ The protection of a physician’s rights of freedom of speech and freedom of religion is “clearly a compelling state interest.”²⁶⁰ Many states then enacted other healthcare refusal laws in the wake of the Church Amendment.²⁶¹ These laws did not just exempt providers from performing abortions or sterilizations, but were expanded to include contraceptive and other practices that the provider might consider immoral.²⁶² Medical futility statutes are just one type of these laws.²⁶³

In the context of physician-assisted suicide and reproductive rights, the Supreme Court has found that physicians are unique, and the state has an interest in preserving their professional ethics and maintaining a distinction between physician’s duties to heal rather than harm.²⁶⁴ As evidenced by a related survey I conducted and published elsewhere,²⁶⁵ providers think administering futile treatment is unethical as they feel they are potentially harming a patient through forced ventilation or feeding without offering any clinical benefit.²⁶⁶ When a patient is on a ventilator, or breathing machine, she cannot speak and is heavily sedated so that the breathing is relaxed.²⁶⁷ This means that the providers have to use indirect measures to assess

²⁵⁸ 42 U.S.C. § 300a-7(b)(1) (2012).

²⁵⁹ § 300a-7(b)(2)(A).

²⁶⁰ Leora Eisenstadt, *Separation of Church and Hospital: Strategies to Protect Pro-Choice Physicians in Religiously Affiliated Hospitals*, 15 YALE J.L. & FEMINISM 135, 167 (2003).

²⁶¹ Douglas Nejaime & Reva B. Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 YALE L.J. 2516, 2538 (2015).

²⁶² *Id.*

²⁶³ *Id.*

²⁶⁴ *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997) (“The State also has an interest in protecting the integrity and ethics of the medical profession. . . . [P]hysician-assisted suicide could, it is argued, undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming.”).

²⁶⁵ Brown I, *supra* note 42.

²⁶⁶ *Id.*

²⁶⁷ *What to Expect While on a Ventilator*, NATIONAL HEART, LUNG, AND BLOOD INSTITUTE (Feb. 2011), <https://www.nhlbi.nih.gov/health/health-topics/topics/vent/while>; see also Judith Ann Tate et al., *Anxiety and Agitation in Mechanically Ventilated Patients*, 22 QUALITATIVE HEALTH RESEARCH 157, 157 (2012).

discomfort. They cannot ask the patient directly whether she is in pain. In some cases, the patient might need to have her hands tied down so that she does not regain consciousness and try to pull the irritating breathing tube out of her mouth.²⁶⁸ Forcing providers to administer medically ineffective treatment that might cause great discomfort to the patient compromises the professional ethics of the medical community, and blurs the line between healing and harming. This provides a second compelling state interest in denying a religious exemption to medical futility laws.

Even the staunchest of religious freedom supporters recognize that public health and safety concerns present compelling state interests.²⁶⁹ During the last swine flu outbreak, many public health authorities realized they needed to develop guidelines on the proper rationing of ventilators in the event of another flu epidemic.²⁷⁰ This was in response to hospitals being at capacity with their ventilators, and states not having policies in place for how to best allocate these scarce and expensive resources.²⁷¹ If religious patients could commandeer the use of the ventilator indefinitely with First Amendment protection, this could thwart public health efforts. This presents another robust

²⁶⁸ Lorraine Mion et al., *Patient-Initiated Device Removal in Intensive Care Units: A National Prevalence Study*, 35 CRITICAL CARE MED. 2714, 2715 (2007) (“...maintenance of therapeutic devices is a primary reason for use of physical restraints in ICUs.”).

²⁶⁹ James E. Ryan, Smith *and the Religious Freedom Restoration Act: An Iconoclastic Assessment*, 78 VA. L. REV. 1407, 1442 (1992) (“The National Council of Churches... have suggested that religious practices be restricted only when they threaten ‘public health and safety.’”).

²⁷⁰ One problem identified by North Carolina’s department of health was that in the event of a flu epidemic, there would not be enough ventilators: “During the worst week of an extreme global epidemic, demand could outstrip the state’s supply of these devices by more than 300 percent, federal computer models indicate.” See Jim Nesbitt, *N.C. Arms Against Threat of Flu Pandemic*, NORTH CAROLINA NEWS & OBSERVER (Nov. 26, 2006), http://www.ncprogress.org/PDF/120306-newsobserver.com_NC_arms_against_threat_of_flu_pandemic.pdf; see also Press Release, New York State Health Department, *New York State Health Department Seeks Public Engagement on Ventilator Allocation Guidelines* (Aug. 23, 2007), https://www.health.ny.gov/press/releases/2007/2007-08-23_vent_comments.htm; Sheri Fink, *Preparing for a Pandemic, State Health Departments Struggle With Rationing Decisions*, PROPUBLICA (Oct. 24, 2009), <https://www.propublica.org/article/preparing-for-a-pandemic-state-health-departments-struggle-rationing-1024>.

²⁷¹ See Nesbitt, *supra* note 270.

and compelling state interest in denying a religious exemption to medical futility laws.

In addition to these professional autonomy and public health compelling interests, the state has an interest in preventing “an administrative problem of such magnitude” as to render the religious exemptions unworkable.²⁷² In the context of medical futility statutes, the state’s interest here is exceedingly strong. The basis for this interest is the inability of distinguishing between sincere and insincere religious requests.²⁷³ A state’s interest may become compelling when viewed in the aggregate, even if it might not be as compelling when viewed through one specific claim.²⁷⁴ As William Marshall explains,

[i]f, for example, one factory is exempt from anti-pollution requirements, the state’s interest in protecting air quality will not be seriously disturbed. When many factories pollute, on the other hand, the state interest is seriously threatened. Weighing the state interest against a narrow class seeking exemption is similar to asking whether this particular straw is the one that breaks the camel’s back.²⁷⁵

The 2014 *Hobby Lobby* case made clear that the compelling state interest should be determined by looking “beyond broadly formulated interests” to “scrutiniz[e] the asserted harm of granting specific exemptions to particular religious claimants.”²⁷⁶ This means that the state should question whether the marginal interest is compelling in denying *this particular type of exemption* to this class as opposed to its global state interest in passing the statute as it applies to everyone.

²⁷² *Sherbert v. Verner*, 374 U.S. 398, 408–09 (1963).

²⁷³ *Thomas v. Rev. Bd. of Indep. Emp’t Sec. Div.*, 450 U.S. 707, 716 (1981) (“[I]t is not within the judicial function and judicial competence to inquire whether the petitioner or his fellow worker more correctly perceived the commands of their common faith. Courts are not arbiters of scriptural interpretation.”)

²⁷⁴ Marshall, *supra* note 136, at 312.

²⁷⁵ *Id.*

²⁷⁶ *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2779 (2014) (quoting *Gonzales v. O Centro Espirita Beneficente do Vegetal*, 546 U.S. 418, 431 (2006)).

c. The Compelling Interests Must Also Be the Least Restrictive Means Necessary

Even though promoting professional autonomy and ethics and public health interests are each considered compelling, just as with all other state interests, they must also be the least restrictive necessary.²⁷⁷ The Seventh Circuit recently reminded us in the context of the Affordable Care Act's mandatory contraception coverage, "[s]trict scrutiny requires a substantial congruity—a close 'fit'—between the governmental interest and the means chosen to further that interest. . . . There are many ways to promote public health and gender equality, almost all of them less burdensome on religious liberty."²⁷⁸ The government cannot prevail by articulating general compelling interests.²⁷⁹ The contraceptive mandate in *Hobby Lobby* ultimately failed for this reason, as the Supreme Court conceded that the state interests in not requiring cost-sharing for women might be compelling.²⁸⁰ However, those challenging the mandate successfully argued that the federal government *could* subsidize the purchase of contraceptives for employees whose religious employers rejected coverage.²⁸¹ This meant that the mandatory contraception coverage violated the federal RFRA because it was not the least restrictive means necessary for furthering the cost-sharing and public health interests.²⁸² Because the various state RFRA's also require strict scrutiny, the state's interests must also satisfy this "least restrictive" burden.²⁸³ However, for some of the states' interests in medical futility statutes, this burden is more easily overcome.

²⁷⁷ *Id.* at 2759.

²⁷⁸ *Korte v. Sebelius*, 735 F.3d 654, 686 (7th Cir. 2013).

²⁷⁹ *Burwell*, 134 S. Ct. at 2779 ("HHS asserts that the contraceptive mandate serves a variety of important interests, but many of these are couched in very broad terms, such as promoting 'public health' and 'gender equality'. . . . RFRA, however, contemplates a 'more focused' inquiry: it 'requires the Government to demonstrate that the compelling interest test is satisfied through application of the challenged law 'to the person'—the particular claimant whose sincere exercise of religion is being substantially burdened.'").

²⁸⁰ *Id.* at 2781.

²⁸¹ *Id.* at 2782.

²⁸² *Id.* at 2782.

²⁸³ See 42 U.S.C.A. §§ 2000bb–1(a)–(b) (West 2016) (requiring the Government to "demonstrate[] that application of [a substantial] burden to *the person* . . . is the least restrictive means of furthering [a] compelling governmental interest" (emphasis added) (as quoted in *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2780 (2014)).

As applied to medical futility statutes, there are, indeed, other ways the state could control against the inability to ration life-sustaining care in the event of a pandemic. Specifically, the state could suspend medical futility statutes in the event of a pandemic, but not before. Therefore, a medical futility statute that applies in non-pandemic situations may not be considered the least restrictive necessary for this particular need to ration life-saving technologies during public health crises. The states would need to advance another compelling interest to ensure that the statute passes a state RFRA analysis.

A better source for upholding medical futility statutes is the state's interest in professional autonomy and ethics. Medical futility statutes that do not provide adequate means for the patient to transfer (e.g., by not affording the family a sufficient amount of time to locate an alternative facility) might violate a state RFRA by not being the least restrictive means necessary to further this specific government interest. However, if the statute provides for some amount of notice to the patient or his family and an opportunity to find an alternative provider, it would likely satisfy strict scrutiny. The state could argue that the provider's autonomy is not excessively infringed if the provider must give the family a week's notice before terminating futile treatments. But the physician's autonomy and professional ethics would be violated by forcing them, on the patient's religious grounds, to provide indefinite futile treatments. The state has a clear interest in limiting the patients' ability to commandeer providers in this way.

The state's interest in managing the administrative burden bolsters the "least restrictive" prong of strict scrutiny. As Thomas Berg explains, "[t]he threat of cumulative exemptions comes not only from other sincere religious objectors, but from other persons who could feign the same objection to get the benefits of exemption."²⁸⁴ Further, the text of the First Amendment constrains any deep scrutiny into desperate patients who might try to game the system, because the state cannot

²⁸⁴ Thomas C. Berg, *What Hath Congress Wrought? An Interpretive Guide to the Religious Freedom Restoration Act*, 39 VILL. L. REV. 1, 41 (1994).

inquire too closely into whether the belief is truly religious, sincere, or even shared with other members of the same faith.²⁸⁵

Given that many people find religion and God near the end of their lives and in response to medical crisis, limiting the exemptions to a manageable number would be impossible. Here the analysis of whether the interest is compelling dovetails with the question of whether the statute is the least restrictive means necessary. The fact that there is no way to more narrowly tailor the statute to protect religious freedoms renders the interest in categorical non-exemption compelling and also the least restrictive means necessary.

Any patient could request that they be provided indefinite life support on religious grounds. This could happen if patients became aware that this was the only way to receive futile treatment. The inability to distinguish sincere from insincere claims, and the likelihood that most patients could feign sudden belief in miracles bolsters the state's claim that the statutes are the least restrictive means possible to further the stated legislative interests. The nature of medical futility decisions is unique. There are no alternatives to indefinitely providing futile treatments. The only potential concession, though not an alternative, is to grant these patients a certain amount of time to pray for a miracle, which many providers (and futility statutes) already do.²⁸⁶ Unilateral withdrawal is almost never invoked unless the team has already given the patient a significant amount of time to recover.²⁸⁷ Despite this, there must be some principled limit on the amount of time a patient or his surrogate could mandate clinically futile care. Otherwise, without a limit, once clinically futile treatment is provided, it becomes impossible to introduce another non-arbitrary reason for withdrawing the treatment at a later date. The medical standard of care provides that principled limit. Any other standard introduces an arbitrary limit, and creates its own potential for unfair discrimination.

Contrast this with the religious freedom cases where exemptions were granted. The exemptions from working on the

²⁸⁵ See *Thomas v. Rev. Bd. of Indep. Emp't Sec. Div.*, 450 U.S. 707, 716 (1981); *Welsh v. U.S.*, 398 U.S. 333 (1970); *U.S. v. Seeger*, 380 U.S. 163, 176 (1965).

²⁸⁶ See *Brown II*, *supra* note 95.

²⁸⁷ *Misak, White & Truog*, *supra* note 96, at 1668.

Sabbath, are not likely to overwhelm employers or employee benefit programs. For personal reasons, other employees will choose to work on Saturdays and a minority of religions celebrate a Saturday Sabbath. In those contexts, the fear of numerous (even feigned) religious exemptions does not swallow the statute and make it unworkable. There *is* potential for high school students to request not to finish high school on religious grounds, such as those made by the Old Order Amish in *Yoder*.²⁸⁸ However, either the Supreme Court was not concerned that these exemptions would overwhelm the states or they felt that in that particular case the Old Order Amish had demonstrated sufficient sincerity and vocational alternatives.²⁸⁹ Either way, respected religious freedom scholars such as Douglas Laycock agree that “the number of potential claims is relevant to assessing the government's interest . . . if the government has a compelling interest in denying exemption to the whole group of similarly situated objectors, it also has a compelling interest in denying exemption to each one of them.”²⁹⁰

d. There Are at Least Three Compelling State Interests that Are the Least Restrictive Means Necessary

There are at least three state interests that are compelling and the least restrictive means necessary. These are: a) respect for the professional autonomy of physicians, b) the need to distinguish harming patients from healing, and c) the need to manage the administrative burden of numerous claims. Given the multiple compelling state interests in denying a religious exemption in medical futility cases, and the inability to accommodate religious believers without exposing hospitals and providers to an unlimited conscription of services, it seems

²⁸⁸ *Wisconsin v. Yoder*, 406 U.S. 205, 214 (1972).

²⁸⁹ *Id.* at 235–36. This concern seems to have been implicit in Justice White's concurring opinion in *Yoder*: “This would be a very different case for me if respondents' claim were that their religion forbade their children from attending any school at any time and from complying in any way with the educational standards set by the State.” *Id.* at 238. However, Justice Douglas's dissenting opinion emphasizes his perceived irrelevance of this sort of inquiry: “[T]he emphasis of the Court on the ‘law and order’ record of this Amish group of people is quite irrelevant. A religion is a religion irrespective of what the misdemeanor or felony records of its members might be.” *Id.* at 246 (Douglas, J., dissenting).

²⁹⁰ Douglas Laycock, *RFRAs, Congress, and the Ratchet*, 56 MONT. L. REV. 145, 148 (1995).

quite unlikely that a petitioner would prevail on state RFRA grounds.

i. Religious Patients Would Likely Not Prevail on a Free Exercise Claim

Given that the medical futility statutes likely satisfy the strict scrutiny required of the state RFRA, they therefore also satisfy the lesser-included rational basis test required of the First Amendment. Recall that following *Smith*, the federal Constitution does not require a state's interest in the statute to be compelling if it is generally-applicable, which all of the medical futility statutes are.²⁹¹ The federal RFRA does not apply to state laws. Therefore, we can conclude that religious patients claiming that medical futility statutes violate their religious free exercise will have a very difficult time prevailing. Even so, this only answers the legal questions.

CONCLUSION

Unfortunately, when physicians concern themselves chiefly with the legal ramifications, they lose sight of the important ethical dimensions of these cases. Whereas the courts are not allowed to inquire into whether a patient's religious belief is sincere or shared with members of their faith, this is precisely what a chaplain or social worker should do. Outside of the domain of constitutional law, one medical scholar claimed that:

[c]laims about miracles may . . . be subjected to scrutiny according to the criteria of the patient's faith. Faith is, in this sense, public and not private. Judging the authenticity of patients' or families' claims about miracles therefore involves examining such claims in light of the deposit of faith of the person's own religious tradition.²⁹²

Knowing whether the patient shares these beliefs with members of her faith is crucial to ruling out denial or negative psychological coping. In many cases where a patient begs for more time for a miracle to occur, the patient is likely unprepared

²⁹¹ *Emp't Div., Dep't. of Human Res. v. Smith*, 494 U.S. 872, 890 (1990).

²⁹² Daniel Sulmasy, *Distinguishing Denial From Authentic Faith in Miracles: A Clinical-Pastoral Approach*, 100 SOUTHERN MED. J. 1268, 1268 (2007).

for death and expressing this in terms of needing a divine intervention. Inquiring into the basis of the belief in miracles would allow the clinical team to determine whether the patient is a true believer, or in need of psychological as well as spiritual counseling before the treatments are refused or withdrawn. Focusing on these dimensions allows providers to ask the pressing ethical questions that would not be allowed or encouraged under a pure constitutional or RFRA analysis. Efforts to educate providers should disambiguate the legal from the ethical, and emphasize the ethical importance of asking questions that are foreign to the law.